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British Medical Association.

NINETY-FIFTH ANNUAL MEETING, EDINBURGH, 1927.

President's Address

ON

THE STRATEGIC FRONT OF MEDICINE TO-DAY.

BY

SIR ROBERT PHILIP, M.D., F.R.C.P.ED., LL.D., HON. F.R.C.S.ED.,
HONORARY PHYSICIAN TO HIS MAJESTY IN SCOTLAND; PHYSICIAN CONSULTANT, ROYAL INFIRMARY, EDINBURGH.

THIS is not the first time that the British Medical Association has come to Edinburgh. The city has been honoured as its meeting place on three previous occasions—in 1858, in 1875, and in 1898. In 1858 the meeting was presided over by Dr. William Pulteney Allison, professor of medicine in the University of Edinburgh. The number of members attending the meeting is recorded as 170. In 1875 the President was Sir Robert Christison, professor of materia medica in the University of Edinburgh. The number of members attending the meeting is recorded as 1,003. In 1898 the meeting was presided over by Sir Thomas Grainger Stewart, professor of medicine in the University of Edinburgh. The number of members attending the meeting is recorded at 1,915 (including 64 foreign guests and visitors).

To-night, on the occasion of this reassemblage, there falls to me the privilege of offering to the Association, and to its distinguished guests from all parts of the world, a very hearty welcome on behalf of the profession and the citizens of Edinburgh and the surrounding country. Most of you are familiar with the name of the ancient city. Some of you have been drawn to the meeting by the fame of her university and medical school. Many have returned with filial longings to the kindly mother—still going strong, notwithstanding the 345 summers she has seen—and will revisit the old school and its pleasant byways. Some of you are here because of the romance of her history and the lure of her streets and wynds. We trust that all of you will feel at home and enjoy one of the times of your life. In bidding you welcome, it is likewise my dutiful wish to tender to the members of the Association, and particularly to colleagues in the Edinburgh area, grateful and respectful thanks for their graciousness in inviting me to occupy this chair. The presidentship carries with it not only honour, but responsibilities. I should gladly have seen those borne by shoulders more worthy of both. As it is, I thank you from the bottom of my heart.

B.M.A. Links with Edinburgh: Charles Hastings.

The past meetings are far from constituting the sole links between the Association and the city. Throughout the ninety-five years which have passed since the foundation of the Association in 1832, Edinburgh has drawn on the resources of the Association in many directions, and, in turn, has contributed a goodly quota of members and office-bearers of all ranks. The mutual relationships have been pleasant and stimulating. Will it be thought fanciful if I suggest a relationship of an earlier and closer sort between the Association and Edinburgh—a link which may be called ancestral?

One hundred and twelve years ago—in the year of the battle of Waterloo—there came to Edinburgh from the city of Worcester, as a student of medicine, one Charles Hastings. The young man was not, even then, an unknown quantity. For previous to matriculation at Edinburgh Charles Hastings had served an honourable apprenticeship with Dr. Wilson Philip, Fellow of the Royal College of Physicians of London, a man of high repute in Worcester, and an investigator in experimental medicine.

Young Hastings reached Edinburgh imbued with the traditions of scientific medicine and with a flair for culture and sport. He was fond of shooting, hunting, and racing. By happy introduction to members of the Senatus he was thrown into the social life of the university and the city. And what a brilliant period it was! Lord Cockburn says that Edinburgh society "had never been better, or indeed so good" since he knew it. "Its brilliancy was owing to a variety of peculiar circumstances which only operated during this period. The principal of these were—the survivance of several of the eminent men of the preceding age, and of curious old habits which the modern flood had not yet obliterated; the rise of a powerful community of young men of ability; the exclusion of the British from the Continent, which made this place, both for education and for residence, a favourite resort of strangers; the war, which maintained a constant excitement of military preparation, and of military idleness; the blaze of that popular literature which made this the second city in the empire for learning and science; and the extent, and the ease, with which literature and society embellished each other, without rivalry, and without pedantry."

Waverley had just been published, and the enigma of its authorship was tickling literary curiosity. Our morning paper, the *Scotsman*, made its first appearance in January, 1817. A walk along High Street or Princes Street meant, perhaps, to meet Walter Scott, unmistakable in feature and carriage, "graced by gaiety, simplicity, and kindness," Henry Cockburn, Francis Jeffrey, James Gregory, Andrew Duncan, John Barclay, Thomas Chalmers, Francis Horner, Henry Mackenzie, Dugald Stewart, or other celebrity.

Hastings's medical teachers included Andrew Duncan, Gregory, Hamilton, Hope, Monro, and Daniel Rutherford. Christison and Syme were students about the same time. Conspicuous among his undergraduate activities was his attachment to the Royal Medical Society—that venerable institution "with the excellent and laudable object of advancing medicine" which received its Royal Charter from King George III (1778), and which has stood for untrammelled discussion of things medical on the part of students and young graduates. It is interesting to note that in the Royal Charter, two of the four Presidents named are James Melliar, Somerset, and Caleb Parry, Gloucester. Speaking of the Society at that date, Sir Robert Christison says: "Of its four Presidents, chosen annually in the main for their popularity in debate, very few have failed to distinguish themselves in professional life, either as successful physicians, or in the walks of the medical sciences." Hastings took a lively part in the proceedings of the Society, and was elected President in 1817 while still an undergraduate.

The following year he returned to Worcester, and was elected physician to the hospital at the early age of 24. Successful in practice, he yearned for something more—a larger intellectual life. Does it seem far-fetched to suppose that recollections of the cultured life he enjoyed in Edinburgh, and particularly the friendly association with fellow

students and the free exchange of opinions at the Royal Medical Society, played a considerable part in the longing which culminated in the establishment of the Midland Medical and Surgical Reporter and the subsequent foundation, in 1832, of the Provincial Medical and Surgical Association, which presently—in 1856—was re-baptized the British Medical Association, whose ninety-fifth Annual Meeting has this day been constituted?

It is pleasant to imagine that the youngster who, as a student, saw the beginnings of the new town of Edinburgh, and probably danced on some of its floors, and brought down a pheasant in the neighbouring woods of Drumsheugh (now Drumsheugh Gardens) did imbibe here some of the lessons of comradeship in medical science which inspired his vision of an Association for the diffusion and increase of medical knowledge, and the maintenance of the honour and respectability of the profession, by promoting friendly intercourse among its members, and by establishing among them harmony and good feeling.

Meeting at Edinburgh, 1875: Joseph Lister.

Without pressing the plea for Edinburgh as the spiritual home of the Association, let me ask you to place yourselves in the city fifty years ago, and reconstitute some of the features of the meeting in 1875—the stir of which I can just recall.

There sat in the presidential chair of the Section of Surgery a man whose genius was already remodelling the face of surgery, and who was destined to impress his plastic touch on the wider lineaments of medicine. I cannot trace whether Joseph Lister attended the 1858 meeting. He may well have done so, for he was admitted a member of the Harveian Society of Edinburgh in the year 1856, and was appointed assistant surgeon to the Royal Infirmary in October of that year. Whether present or not, he was already a vital force. Thirty-one years of age, he had overtaken extensive histological researches on the contractile tissue of the eyes, muscular tissue of the skin, involuntary muscular fibre, relation of the nervous system to contraction of the arteries, causes of coagulation of the blood in diseases of the blood vessels, function of the visceral nerves, and other subjects. In June, 1857, he had read to the Royal Society his classic monograph on "The early stages of inflammation." The last has "formed the basis of all subsequent discoveries, and the conclusions drawn are as valid to-day as they were then."

The interval between the 1858 and the 1875 meetings was synchronous with the conception and elaboration of his larger enterprise—the antiseptic system. Much regarding that is known to this audience. At this meeting, which coincides with the centenary of his birth, there will be occasions when the successive stages in the development of that mighty work will be underlined by those who, from intimate association with Lord Lister, or with the department he served, are entitled to speak with authority. The present generation, accustomed to the freedom with which every portion of the human frame is handled by the surgeon of to-day, can but dimly realize the state of things which prevailed prior to the renaissance which Lister inaugurated, or the difficulties that had to be overcome before the final success.

While there were giants in surgery before Lister, and remarkable development of resource and technique, the possibilities of the greatest were limited by the attendant risks of inflammation and putrefaction. Prolonged delay in the healing process was apt to be associated with the occurrence of pyaemia, septicaemia, and hospital gangrene. For the patient the prospective risks were formidable, including protracted illness, prostration, imperfect recovery, and, too frequently, death. Notwithstanding the exclusion of pain by anaesthesia, "patients, no matter how critical their need, dreaded the very name of hospital, and the most skilful surgeons distrusted their craft." The practice of surgery was restricted largely to urgent conditions. The skilled surgeon, to whom technically all things were possible, had his venturesome spirit curbed by the ever present menace. Cockburn, writing of 1847, says: "The whole paying surgical practice of Scotland would scarcely keep one gentleman-like scalpel going."

Homage to Pasteur.

The mystery of putrefaction haunted Lister's imagination. Impelled by an irresistible call, he groped his way dimly until 1865, when, as professor of surgery at Glasgow, he was directed by a colleague to the researches of Pasteur. The field of vision became illuminated. In his own words: "When it had been shown by the researches of Pasteur that the septic property of the atmosphere depended, not on the oxygen or any gaseous constituent, but on minute organisms suspended in it, which owed their energy to their vitality, it occurred to me that decomposition in the injured part might be avoided without excluding the air, by applying as a dressing some material capable of destroying the life of the floating particles." On that principle he proceeded to base his practice. Thenceforward each move was directed by inspired purpose. The realm of surgery was bathed in light. Lister's vision unfolded itself in real life.

In the Address on Surgery delivered before the British Medical Association at Plymouth in 1871 he told the story of the revolution simply and forcibly. "Wards (in Glasgow) once among the most unhealthy in the kingdom, were converted into models of healthiness, simply as the result of antiseptic treatment. And during the whole of my Edinburgh period—now almost two years—in wards containing nearly sixty beds, we have not had a solitary case of pyaemia, whilst we are also entirely free from hospital gangrene and from erysipelas." He was able to quote similar records from British and Continental hospitals. Then, recalling the apathy of many of his surgical colleagues, he asked, in the language of Macbeth:

> Can such things be,
> And overcome us like a summer's cloud
> Without our special wonder?

As President (for the second time) of the Section of Surgery at the Meeting of the Association at Edinburgh in 1875, Lister gave an address on "The effect of the antiseptic treatment upon the general salubrity of surgical hospitals." In support of the claim, and in illustration of the extraordinary change that had been wrought, a remarkable mass of evidence was submitted from leading Continental surgeons of the period. In the words of Professor Saxtorph of Copenhagen: "If you ask me what I have observed respecting the effects of antiseptic treatment, I may say that it has not modified, but completely changed my principles of pathology and my surgical practice. . . . The word, *hospitalism*, which some years ago found its way from Edinburgh to the Continent, no longer terrifies us; it no longer keeps us from performing operations in the infirmary, and you seldom meet with a case that could be called a case of hospital disease. . . . In short, I think I am right in saying that patients very seldom die from an operation." As Trendelenburg put it later: surgical practice "had become changed from the very bottom."

Ave Triumphans.

Thus by process of peaceful penetration—not, indeed, unopposed—congenial to the man of visage "benign and proud and shy" . . . "of faultless patience and unyielding will, beautiful gentleness and splendid skill," there was effected a revolution touching mankind universally—a revolution whose reverberations, audible to the sympathetic listener-in all over the world, have not yet been exhausted. Lister's personality was the paramount factor. If inborn quality and family circumstances gave him a good start, the crowning success was due to unwearying patience as a seeker after truth, constant questioning of nature, unflinching purpose, and unswerving devotion to his fellows. For

> he preserved from chance control
> The fortress of his 'stablisht soul;
> In all things sought to see the Whole;
> Brooked no disguise;
> And set his heart upon the goal,
> Not on the prize.
>
> With those Elect he shall survive
> Who seem not to compete or strive,
> Yet with the foremost still arrive,
> Prevailing still:
> Spirits with whom the stars connive
> To work their will.

Parallel Advances in other Fields.

If Listerism embodied the fruitful protest of a master mind before the hecatombs which desecrated surgical practice in his time, Listerism did not stand alone. Other influences were at work making for the betterment of national health. Lister was a mighty pioneer. He was at the same time the expression of his age. Side by side with the development of the revolution in surgery there were indications of the coming wave of preventive medicine which, reinforced by Listerism, was destined to advance with the certainty of a tide.

Grim Features of Communal Life.

In the first half of the nineteenth century health conditions throughout the country afford in the wider sphere a striking parallel to the grim condition of hospitalism which Lister found himself up against.

Many pictures might be drawn from town and country. The state of matters in the metropolitan area about the time of Queen Victoria's accession may be described in the words of Dr. Southwood Smith, physician to the London Fever Hospital. Writing of the year which ended March 20th, 1838, and of the districts inhabited by the poorer classes, he says: "Such is the filthy, close, and crowded state of the houses, and the poisonous condition of the localities in which the greater part of the houses are situated, from the total want of drainage, and the masses of putrefying matters of all sorts which are allowed to remain and accumulate indefinitely, that, during the last year, in several of the parishes, both relieving officers and medical men lost their lives in consequence of the brief stay in these places which they were obliged to make in the performance of their duties. Yet in these pestilential places the industrious poor are obliged to take up their abode; they have no choice; they must live in what houses they can get nearest the places where they find employment. By no prudence or forethought on their part can they avoid the dreadful evils to which they are thus exposed. No returns can show the amount of suffering which they have had to endure from causes of this kind during the last year; but the present returns indicate some of the final results of that suffering; they show that, out of 77,000 persons, 14,000 have been attacked with fever, one-fifth part of the whole; and that, out of the 14,000 attacked, nearly 1,300 have died. . . . It is notorious that this disease has been very prevalent during the last year among the industrious classes who have never received parochial relief, and that it has found its way even into the dwellings of the rich, where it has proved extremely mortal. Generated in Bethnal Green, in Whitechapel, in St. George-the-Martyr, in Lambeth, in Holborn, etc., it has spread to the better streets in the immediate neighbourhood of these and similar places, and thence to still wider and more airy streets at a greater distance, and ultimately to the most remote streets and the great squares."

Chadwick's Reconnaissance.

It was amid such surroundings that the sanitary conscience was awakened within the breast of Edwin Chadwick, who stands related to the development of public health somewhat as Lister is to the renaissance of surgery. To Chadwick's healthy, sane mind the world seemed a "lazar-house, wherein were laid numbers of all diseased." Environmental conditions made healthy life impossible. There was no escape, save by reorientation and reform. Queen Victoria had just been crowned, Lister was 10 years of age, and Chadwick 37. Yet Britain was apparently spending little more than £2,000 per annum towards everything that concerned public health.

Thence onwards, throughout a long life, Chadwick's thought and energy were constantly directed towards the recovery of the nation from the inevitable consequences of blindness and inaction. His secret "lay in the conception that the life of man is so entirely influenced and affected by its surroundings, that by a perfected sanitary code the death rates may be made, practically, whatever we like to make them, until we arrive at that natural duration of human existence which is bounded by anatomical or physiological law."

Impelled by such considerations Chadwick began his insistent inquiries into the condition of London and the health of the labouring classes of other parts of England and Wales, which led to the appointment of the Sanitary Commission in 1844, and the formation in 1848 of the short-lived first Board of Health, of which Chadwick was one of four commissioners. Thereafter his labours—in chief part unofficial—were unceasing in relation to every aspect of sanitation in Britain and elsewhere. He was recognized widely outside Britain as one of the great master spirits, one of the first to awaken the careless public all over the world to the dangers they were creating for themselves. In France, towards the end of his life, he was described as "une des gloires de l'Angleterre."

Even if temperamentally he was not of the kind who drew all men unto him, Chadwick did not stand alone. He had close colleagues and keen fellow workers. Among those may be named especially Dr. Southwood Smith, Dr. Kay, and two men having special connexions with Edinburgh—namely, Dr. Neil Arnott and Professor W. P. Allison, who occupied this Chair at the 1858 meeting, and of laymen, Lord Shaftesbury, Charles Kingsley, and Florence Nightingale.

Dawn of Preventive Medicine.

From 1840—when, thanks to William Farr, our system of registration began to have value—up to 1870, the death rate of England remained uniformly high—over 22 per 1,000 of the population. In 1869 the Royal Sanitary Commission was appointed "to inquire into and report upon the operation of the various laws then in force for promoting the public health and preventing epidemic diseases; and into and upon the administration of those laws, including the constitution of the administrative authorities, central and local, and the formation of areas proper to be controlled by local authorities; and into and upon the operation of the registration system in respect of certificates of causes of death; and the Commission was to suggest improvements in all or any of those matters, with the means for carrying such improvements into effect."

It is significant that the Royal Commission of 1869 followed the submission of a memorial to the Government by a joint committee appointed by the British Medical Association and the Social Science Association "to promote a better administration of the laws relating to registration, medico-legal inquiries, and the improvement of the public health."

Report of Royal Commission.

The Commissioners reported in 1871, and their recommendations, which have a remarkably fresh ring, included the following: "The present fragmentary and confused sanitary legislation should be consolidated; the administration of sanitary law should be made uniform, universal and imperative throughout the kingdom; all powers requisite for the health of towns and country should in every place be possessed by one responsible local authority, kept in action and assisted by a superior authority; there should be one local authority for all public health purposes in every place, so that no area should be without such an authority, or have more than one; the administration of the laws concerning the public health and the relief of the poor should be presided over by one minister . . . whose title should clearly signify that he has charge of both departments; the central authority . . . charged in one of its departments with the superintendence of all sanitary authorities, and equipped with a sufficient staff of officers . . . must nevertheless avoid taking to itself the actual work of local government; we would leave *direction* only in the central power. . . . The new department will have to keep all local authorities and their officers in the active exercise of their own legally imposed and responsible functions; to make itself acquainted with any default and to remedy it; it will have also to discharge to a much greater extent its present duties . . . namely, to direct inquiries, medical or otherwise, to give advice and new plans when required, to sanction some of the larger proceedings of the local authorities, to issue provisional orders subject to parliamentary confirmation, to receive complaints and appeals, to issue medical regulations on

emergencies, and to collect medical reports; every local authority should have at least one officer of health, being a legally qualified medical practitioner, or possessing such other qualification in medical science as shall be declared by the central authority to be satisfactory."

State Assumes Responsibility.

The recommendations of the Commission were accepted in 1871 by Parliament. The Local Government Board—one for each division of Britain—was established. This constituted an initial step of first importance in the sphere of health. The State and Legislature now recognized as never before the meaning and value of the health of the people, assumed responsibility for its maintenance, and began to shape machinery on a national scale for its preservation and improvement.

The establishment of the Local Government Board, so far as it concerned health, implied (*a*) central guidance and direction, and (*b*) peripheral (local) interest and activity. It fell to the President of the Local Government Board, supported by eight ministerial colleagues and expert advisers, to consider matters affecting communal health and demands made by the quickened intelligence of the nation. Even if the Local Government Board seldom or never met, it devolved on the President to keep in close organic touch with 1,809 local councils or boards which constituted the system. To those local bodies were assigned duties and responsibilities. Thus, the appointment by each sanitary area of a medical officer of health and a sanitary inspector was enjoined by statute. All this meant a very practical awakening throughout the land.

Sanitas Sanitatum, Omnia Sanitas.

It was on April 3rd, 1872, at a great meeting in Manchester, in a speech which held "an enthusiastic audience with unflagging spirit for three hours and a quarter," that Disraeli recalled a suggestion he had made eight years before at Aylesbury—namely, that the words attributed to the wisest of mankind, "*Vanitas vanitatum, omnia vanitas*," must have been a misquotation, and that the words of the wise king were "*Sanitas sanitatum, omnia sanitas*," and that, if so, they constituted one of his best claims to be considered the wisest of mankind; and Disraeli concluded with the words, "After all, the first consideration of a Minister should be the health of the people."

1875-1927.

Thus far it has been my endeavour to show how, on the one hand, Lister was a forerunner in relation to preventive medicine, and how, on the other, his work reflected and reinforced the trend of thought and effort of his time.

It may be convenient to recall some of the features of medical life round about the 1875 Meeting, and compare them with the present day. A glance at the Calendar of Edinburgh University for 1875 and at the record of the Meeting is enlightening.

In 1875 the Medical Faculty of the University comprised 12 professors and 14 assistants, while the current (1927) list comprises 18 professors, 79 lecturers, and 38 assistants. At the 1875 Meeting of the Association the separate Sections numbered 6, while on the present occasion—after scrupulous pruning by the Arrangements Committee—they number 21. Reference to the titles of discussions and papers in 1875 emphasizes the striking difference of outlook. The principles of preventive medicine, as understood to-day, were little in evidence. Of the numerous papers and subjects under discussion the only allusion to prevention occurs in connexion with scarlet fever, puerperal fever, and miscarriages. The relation of disease to micro-organismal life hardly emerges, apart from Lister's opening address. Bacteriology had not come into being. In 1875, for the first time, there was a Section of Public Health, presided over by the Right Hon. Lyon Playfair, M.P. Yet it is to be observed that the subjects brought before the Section included for the most part topics bearing on ventilation, drainage, vital statistics, the meteorological relationships of disease, etc., with little indication of the preventive outlook in the modern sense.

Has the Practice of Medicine Advanced since Hippocrates?

At the Meeting in 1875 the Address in Medicine was delivered by one of the most thoughtful physicians of his age, Dr. James Warburton Begbie. He took for his subject "Ancient and Modern Practice of Medicine," and by way of preface quoted a remarkable question asked in 1852 by Sir William Hamilton, who was long the distinguished exponent of philosophy at Edinburgh: "Has the *practice* of medicine made a single step since Hippocrates?"

Sir William Hamilton's rather negative answer to the question was traversed by Dr. Warburton Begbie in an historical review which, even to-day, the student of medicine will find interesting, and by the citation of recent advances in treatment to which, at that date, Dr. Begbie thought reference was especially due. If the champion of medicine in 1875 was able to rebut effectually the reproach implied in the question, how much easier would be the task to-day! It is not my purpose to advance a studied defence. Progress in the practice of medicine during the past fifty years has been phenomenal. Countless illustrations will occur to everyone who is familiar with the developments of the past half-century.

The great wave that was initiated by the genius of Pasteur and reinforced by the originality of von Behring has refreshed the brain of medicine and directed its energies into channels of amazing width. Need I cite the complete revision of outlook and practice in the ever-widening group of infective processes? The adaptation of the principles of scientific cleanliness and the utilization of the elemental properties of air and light, as notably in tuberculosis, have got deep down to the root of things, and given promise in the realm of medicine no less extensive than has been realized by the acceptance of Listerism in the realm of surgery. What more thrilling romance than the story of tropical diseases which, fifty years ago, constituted a *terra incognita* shrouded in mystery and tragedy? Recall the triumphs in relation to cholera, malaria, dysentery, enteric fever, sleeping sickness, and others. Incidentally, I may remind you that it was at the last Meeting of the Association at Edinburgh in 1898 that Sir Patrick Manson revealed to a thrilled audience the demonstration of the transmission of malaria by mosquitos.

Recall the extending list of diseases which have been traced to intoxications and to parasites. The murky, malodorous fog which enveloped venereal disease has been largely dispelled. Syphilis and gonorrhoea are handled openly and scientifically throughout the land.

Recall the great vista opened up by clinical observations and experimental investigation on the ductless glands, which has resulted in a reconception of glandular values and the constitution of a new department of medicine—endocrinology. Recall our present attitude to the nervous system. While the teaching of the nervous system given to undergraduates fifty years ago covered the broad lines of structure, function, and pathological disturbance, the gap is indescribable between that and the precision of to-day, whereby lesions of very varying character can be differentiated and localized almost with the certainty of the physical laboratory. A department of neurology has been constituted, and the practice of psychiatry has become scientific. The old asylum as a house of detention with sombre portal (Abandon hope, all ye who enter here) has become transfigured by the spirit of the age into a home of prevention and a tabernacle of hope.

Diseases of the circulation were well understood fifty years ago. In no department had British medicine rendered more conspicuous service since the days of William Harvey. But think of the increase of knowledge and application of exact methods which the present generation has witnessed. The problem of the circulatory mechanism has been linked with that of the circulating fluid. The secret of blood changes as cause of disease and as expression of disease has been gradually unfolded by patient, original investigations. Cardiology and haematology now form departments of their own.

Similar references might be made to advances in relation to diseases of respiration, digestion, exercion. By the application to medicine of biological principles and chemical and physiological procedure, the physician is throwing

light on the meaning of symptoms and changes previously obscure, and the department of bio-chemistry has emerged.

The natural history of diseases is being followed from the beginning, step by step, through successive stages which almost certainly develop unless the chain of events be broken by other influence. With what remarkable *éclat* this succession of events can be interrupted was dramatically illustrated in the discovery of insulin, which, whatever its ultimate place in the armamentarium of medicine, has effected changes in the life and outlook of a large group of human sufferers such as was hardly conceived possible a few years ago.

Other such therapeutic conquests occur to us all. I am little concerned for the moment with cataloguing their number. My purpose is rather to underline the statement that, within recent years, truly marvellous advances have occurred in the practice of medicine. These have been partly the natural development of lines of observation, long continued, at the bedside and in the *post-mortem* room. In considerable part they have resulted from the absorption into medicine of advances in the basal sciences of biology, physics, chemistry, anatomy, and physiology.

Those illustrations have been culled at random from the field of medicine, in view of Hamilton's question. Examples might have been found no less abundantly in relation to surgery. The point has already been developed in speaking of Lord Lister. Anaesthesia and asepsis paved the way for a sure and rapid development of surgical procedure. Technique became quickly refined and surgery bounded ahead. With the limitless opportunities tragically offered by the war and the urgency of peril which justified the knife as never before, there came the occasion of enterprise to many capable men who otherwise would not have had the chance. Whether the spirit of adventure has carried some of them too far it is not my present purpose to consider.

Most of the so-called specialties have reared their heads since 1875. Many have become lusty growths, scientifically based, beneficent to the sufferer, and not unkindly to the labourer who is worthy of his hire. If the critic speak lightly of the specialist, it is often through ignorance of what specialization in the proper sense means, and the scientific advances it implies. In his turn the specialist will be watchful, lest limitation of the scientific spirit and the presence of other motives give point to the captiousness of the cynic who, ignorant of the verities, is apt to interpret action according to his own standard.

Extension of Front Line.

It is to more general indications of change that I now ask your attention. From the side of the State, following the creation of local government boards, came the gradual development of machinery, both central and peripheral. This was a difficult and delicate matter. The necessary adjustments at both ends required time and patience. Yet, as Sir John Simon says, "the fact that the medical profession had been brought into statutory relations with the local government of the kingdom, even though the relations were yet of rude kind, was obviously in principle a fact of good sanitary promise. . . . The medical profession being of such spirit as it happily is, those who knew it could feel sure that by many of its members who had become officers of health under conditions most disadvantageous and discouraging great exertions would be made, great disinterestedness be shown, in trying to make their individual appointments bear fruit."

An obvious difficulty lay in the fact that local authorities were not all willing to do their part, and, even when they were willing, their knowledge and vision were limited. Time and education were required. It is impossible on the present occasion to follow closely the stages in the evolution of the boards' activities, which included not merely administration, but scientific inquiry and investigation. We must look rather at the outcome of these developments.

The passing of successive Public Health Acts, the National Health Insurance Act, and the Education Act, have stereotyped progressive advances and afforded fresh avenues of thought and effort.

Outward symbols of change are to be found in notification of certain infections, the segregation of fevers and other cases in special hospitals under expert direction, the creation of bodies of medical officers concerned with tuberculosis, maternity, and child welfare, venereal diseases, inspection of school children, etc. Other evidence is yielded in the institution by the universities and licensing bodies of degrees and diplomas in public health, and, in connexion therewith, a special curriculum of training recently revised and extended by the General Medical Council. In Edinburgh University, for example, there was established in 1898 a chair in public health, and about the same time a special institute for the study of preventive medicine; also in 1898 a lectureship on diseases of tropical climates, in 1904 a lectureship on infective fevers, in 1913 a chair in bacteriology, in 1917 a chair in tuberculosis, and in 1919 a lectureship on venereal diseases, all of which have intimate relationships with the problems of prevention, immediate and ultimate. One of the latest outward expressions of the advancing tide is the munificent gift to the nation by the Rockefeller Foundation of £400,000, for the purpose of erecting the London School of Hygiene and Tropical Diseases.

On the eve of the last Edinburgh meeting (1898) it fell to me to publish in the BRITISH MEDICAL JOURNAL an address on the universal applicability of the open-air treatment of pulmonary tuberculosis. At that date there were not more than two or three sanatoriums in Great Britain. To-day there exist in England, Wales, and Scotland, under the control of the State, no fewer than 307 sanatoriums, excluding general hospitals receiving cases of tuberculosis, and 151 voluntary or proprietary sanatoriums. At the date of last meeting there was one tuberculosis dispensary. To-day there are in England, Wales, and Scotland, under the direction of the State, 515 dispensaries, and similar institutions have been established in most countries of the world.

In 1875 the mortality from all forms of tuberculosis in Scotland was 361 per 100,000, while in 1925 it was 110. In 1875 the mortality from pulmonary tuberculosis in Scotland was 252 per 100,000, while in 1925 it was 76. In other words, during the fifty years there has occurred in each case a total drop in mortality of over two-thirds. This is something more than part expression of the reduction of the general death rate of the country, in which the fall during the same period amounted to less than one-half. The relative fall is illustrated by the fact that, while in 1875 deaths from pulmonary tuberculosis constituted 10.6 per cent. of deaths from all causes, in 1925 they constituted only 5.7 per cent.

If in England, Wales, and Scotland the death rate of 1875 had continued there might have been expected in 1925, with the increased population, 107,999 deaths, whereas actually only 36,116 deaths occurred. In other words, there was a saving of 71,883 lives during the year—that is, over 66.5 per cent.

Having regard to the natural history of the disease and the possibilities of well concerted warfare, I ventured in 1910 to prophesy, when speaking of the adoption in New York State of a co-ordinated tuberculosis scheme like that adopted by Britain three years later, that, granted the serious prosecution of the scheme, and special attention to the child as potential tuberculosis seedling, the practical disappearance of tuberculosis might be expected by 1950-55. To-day, in spite of the interruption and difficulties introduced by the war, I am prepared, on the necessary assumption that the methods are vigorously pressed, to believe that my successor at the next Edinburgh meeting—say, thirty years hence—will speak of tuberculosis in this country as largely a memory of the past.

By the passage of the Act which established the Ministry of Health (England) and the Board of Health (Scotland) the State has even more definitely—if language implies anything—shouldered her responsibility in relation to preventive medicine. A beginning has been made towards the inclusion and co-ordination under a common head of administrative departments concerned with health matters. It is not my purpose to discuss the completeness of the provision or the sufficiency of details. There has been a good deal of stumbling and muddling which seems characteristic of progress in England, but the machine, even if

cumbrous and creaking, is functioning throughout the land. I am content for the moment to underline what I believe to be unchallengeable, that Britain possesses the amplest machinery to be found anywhere for the prevention of disease—machinery which, by reason of its completeness from centre to periphery, and its uniformity of operation, is justly the envy of the world.

Widening Objective.

If the present position is relatively good, it has been the outcome of continuous striving after ideals inspired in the earlier days by individual thinkers and workers. But we are far from the last lap in the race.

One thing is clear. Things will not rest where they are. What is to be the line of further advance? The manpower of medicine is vast—greater than ever. The field forces are distributed in instructed groups. They are well officered, and there is abundance of consultative and advisory bodies to whom debatable points may be referred. What is to be the objective of this mighty army? What is the strategic front of medicine to-day?

Medicine has been described as the science and art of healing. Throughout the ages she has been the champion of man against disease and death. Her sacred mission has been expressed variously in successive centuries. Her triumphs have been great.

It has been my endeavour to show that some eighty years ago there began to be evident a great turning movement. The vision of medicine became enlarged and the objective correspondingly altered. Without passing from the care of the individual sick man, for whom Medicine will always have earnest solicitude, she has gradually begun to think in terms of groups and communities. In Britain this change of outlook has been hastened by the great wave of urbanization which has passed over the country—a transfer within less than a century from 75 to 25 per cent. rural population, and from 25 to 75 per cent. urban population. This has inevitably directed thought towards common causal factors of disease—environmental influences which, significant as they are in the individual case, can be studied and interpreted best among the aggregations of men. This has insensibly determined inquiry towards the prevention of disease. This, in turn, has impelled consideration of the early manifestations of disease. Medicine has ceased to be merely the healing art.

Communal Effort: Group Practice.

The fact of illness means much to the sick man, and has a first place in his doctor's mind. Yet from another point of view the treatment of the individual becomes an incident in a larger enterprise. Individual illness means more than it used to do. Its occurrence raises far-reaching questions of cause and of remedy, the solution of which will lead to the prevention of similar occurrence in persons similarly disposed all over the country. Those considerations are of particular significance in relation to widely prevalent diseases, such as cancer, tuberculosis, rheumatism, occupational disorders, etc. Such affections take time to develop. Yet for the most part they are well established before they come under review by the doctor. If medicine is to be effective in respect of those conditions, it can only be by an alteration in the attitude both of doctor and of patient.

The doctor is sometimes called the family adviser. To what extent is the relationship which that term connotes realized? To what extent is it realized in family practice? To what extent is it realized in group practice? The introduction of panel practice—whatever objection may be taken to the particular model established by the statute—has opened great possibilities. The panel doctor, retained as medical adviser, continues to treat illness and accident as before, but he has a potential in relation to persons on his panel which, if thoughtfully used, may make for prevention on a large scale. In view of the form of contract, it is indeed to the selfish interest of the doctor to consider and anticipate environmental conditions likely to prejudice his clientele. It will be to the mutual advantage of patient and doctor that he should become a preventive agent; and the health of the community will be correspondingly advanced.

The principle is readily applicable in all group practice and might advantageously be extended to what is generally known as private practice. What is wanted is a scheme of intelligent protection against illness. Why should not private contracts be arranged on the oriental line of payment for keeping the client well? At least there should be between doctors and patients common agreement as to the advisability of periodic physical examination, on the lines of inspection for recruitment or life insurance, so that morbid tendencies or threatenings of disease may be nipped in the bud.

A number of years ago, when consulted by large employers of labour regarding the frequency of tuberculosis among their workers, it seemed to me right to advise them that "in the light of present-day knowledge, the occurrence of tuberculous disease in a certain number of workers may be interpreted as, in part at least, one of the penalties of industrial life. . . . On economic no less than on scientific grounds there is much to be said for the institution of a method which would insure that every newcomer to a given industry is, prior to admission, specially examined for the presence of tuberculosis—more especially pulmonary tuberculosis—and, if accepted, is thereafter examined, from the same point of view, every four to six months, especially during the first few years." Such a scheme would assure advantage to the individual concerned, to his fellow workmen, and to the employer alike. Some of the great insurance companies across the Atlantic have thought it worth while to arrange for the periodic examination of their policyholders. I have been assured by representatives of one company that from their point of view this is a good business proposition: Prevent serious illness and postpone death. Thereby maintain the annual income of the company though premiums and defer the ultimate payment to the policyholder, who is not likely to complain of the advantage which thus accrues to the company.

Why should such a system of medical examination not become general, and the family adviser be enabled to play his proper part in the prevention of disease? An approach to the method is already in vogue with the dentist, who enjoins his clients to submit to a periodic dental review, to which the client, with experience of pains and penalties, commonly accedes. If the owner of a valuable car thinks it sound economy to send it from time to time to be overhauled at the garage, why should expert overhauling of the human machinery seem less desirable?

Outflanking Movement.

The further disposition of the forces calls for a wider orientation of the field. The ultimate goal is something beyond mere prevention of disease, as commonly understood. The negative attitude is too restrictive. It is scientifically insufficient and unsatisfying. The final triumph of medicine will consist not in the exclusion of disease, but in the restoration to man of perfect form and natural function—the attainment of smooth activity of body, mind, and soul. Biology—anatomy and physiology—must be relied on to carry us further than pathology and therapeutics, as commonly understood. Medicine, thus enlarged, becomes a department of biology and constitutes, *pro tanto*, the science of human life.

Our pathological museums will then serve as agents of preventive medicine. I foresee a time when the bottled preparations—the "beautiful" specimens of to-day—will figure in large part as do ancient manuscripts in our libraries, or as the crude relics of the dark ages in an antiquarian museum. They will stereotype to all time some of the vicious by-products of partial civilization—of imperfect adaptation to environment—and afford cogent stimulus towards prevision. Further recurrence of the conditions they illustrate will come to be regarded as little short of criminal.

Unity of Purpose: Collaborative Effort.

If the larger objective is to be reached there must be unification of purpose and solidarity throughout the forces engaged on the long strategic front. This involves

considerations as to the training of students of medicine, and of candidates qualifying for special diplomas and for the nursing profession. It involves the direction and scope of medical research. It involves questions regarding the utilization and co-ordination of different grades of hospitals and other medical institutions. It involves the relationships of various groups of medical practitioners to one another, and the relationship of the general body of medicine to various departments of the public health service. It involves the mutual relations of medicine and the general public, and the methods for securing trust and compliance. It orients afresh the connexion of medicine with the State. It makes insistent call for international goodwill and co-operation.

Menacing Records.

An unanswerable plea for a reconception—something more than a mere readjustment—of the ordinary medical curriculum is to be found in the report upon the physical examination of men of military age by national service medical boards from November 1st, 1917, to October 1st, 1918, which constitutes "the only survey of the physical fitness of the male population of military age in the history of our country. . . . It seems probable that the men examined during the year under review may be regarded in the aggregate as fairly representing the manhood of military age of the country in the early part of the twentieth century from the standpoint of health and physique, and that deductions founded upon the observations made at the medical examination of these men may legitimately be looked upon as a trustworthy criterion of the national health of this period."

Summarizing briefly the results obtained, the report showed "that, of every nine men of military age in Great Britain, on the average three were perfectly fit and healthy; two were upon a definitely infirm plane of health and strength, whether from some disability or some failure in development; three were incapable of undergoing more than a very moderate degree of physical exertion and could almost (in view of their age) be described with justice as physical wrecks; and the remaining man as a chronic invalid with a precarious hold upon life." An analysis of 10,000 recruit examinations in Scotland between August, 1916, and May, 1917, went to show "that only some 20 per cent. of the male population between 18 and 41 years of age are found free from noteworthy physical defect; so that in time of peace, when the army can afford to choose none but the physically perfect, only about one-fifth would be available for recruiting into the army."

Biology Points the Way.

The system of medical training which allows such findings to be possible lays itself open to the cricitism that there is something wrong somewhere. The eye of the doctor has been insufficiently directed towards the biological problem. Health is born and should be expected. Disease is, for the most part, made and should be excluded. The starting point of medical observation and the ideal of medicine must be health. Were students trained to think biologically throughout the entire course, early departures from perfect form or function would quickly arrest attention and demand explanation.

> Medicine is an art
> Which does mend Nature, change it rather, but
> The art itself is Nature.

At present a hiatus exists between the student's earlier study of biology, physics, chemistry, anatomy, and physiology and his study of disease. There tends to be an abrupt shunting from the consideration of normal processes to that of disease. Disease is apt to be conceived as a definite entity, something to be sought for and labelled in terms of a system of nomenclature. This is unscientific and disastrous. The interrelations of health and disease—and the beginnings of the latter, it may be, in some slight disturbance of the physiological balance—are lost from view. Disease is stereotyped usually in gross form before the aberration from health—determinable earlier—is admitted.

At every point in the curriculum there is call to hark back on the biological scent. George Meredith portrays the proper flair when, after citing some of the revelations of Nature in the life of plant and animal, he proceeds:

> The good physician Melampus, loving them all,
> Among them walked, as a scholar who reads a book.
> For him the woods were a home and gave him the key
> Of knowledge, thirst for their treasures in herbs and flowers
> The secrets held by the creatures nearer than we
> To earth he sought, and the link of their life with ours.
>
> . . . . . .
>
> Divinely thrilled was the man, exultingly full,
> As quick well-waters that come of the heart of earth.
>
> . . . . . .
>
> Where others hear but a hum and see but a beam,
> The tongue and eye of the fountain of life he knew.

Our medical schools must turn out observers and thinkers on biological lines who will thereby be rich in suggestion and resource. The degeneration of our medical schools to mere training workshops must be stayed at all costs.

Inspiration of Research.

The obvious nurseries of medical research are the medical schools—university or other—which exist and are increasing throughout Britain and the Dominions. There the made roads and beaten tracks are familiar ground, and the heads of departments are feeling their way beyond. Unhappy is the plight of the teacher who, occupying the vantage ground of scientific experience and in frequent contact with developing youth, fails to emit the spark that is transmuted into reproductive energy. Unfortunate is the undergraduate whose spirit of inquiry is not roused by contact with one or other Melampus-like leader.

The natural locus of observation and research is the worker's chosen sphere of activity, whether in the laboratory or at the bedside. It is there, as the days go by, that he finds material for inquiry and investigation. The most fruitful researches in medicine have developed commonly from the everyday problem with which the physician or surgeon or practitioner has been faced. The questions which call insistently for an answer emerge often at the beginning of a man's career, when fancy is free and the soul untrammelled. The questions which stirred in the minds of Simpson and Lister were the offspring of recurrent, thoughtful activity in their respective spheres.

The clinical worker may, or may not, happen to be attached to a well equipped laboratory. The uncontrollable nisus towards the light will find ways and means. Lister's researches were conducted for the most part in his own house in Edinburgh and Glasgow, and elaborated as he walked through parks and gardens. Simpson's experiments on anaesthetics were carried out in the dining room at 52, Queen Street. James Mackenzie's work began at the patient's bedside, and in the consulting room of a general practitioner.

The opportunities for observation and investigation in medicine are more abundant than is the number of likely observers. The slogan of original research, which was at one time needed, has been rather overdone and is getting stale. Subjects are often handled in loose and hasty fashion by workers whose preparation for the task has been insufficient. It is growingly more difficult to separate the grain from the chaff. Sound research cannot be contracted for by formal order, however powerful or rich the authority that bids the work, or however complete the equipment of laboratories erected for the purpose.

> Lavish hosts, ye make
> Elaborate preparation to receive
> A shy and simple guest, who, warned of all
> The ceremony and circumstance wherewith
> Ye mean to entertain her, will not come.

Reorientation of Medical Needs.

The provision of well equipped hospitals for the sick is one of the satisfying aspects of our civilization. At first their foundation was for the most part voluntary. The inspiration was humanitarian and Christian. And long may the inspiration continue! The good Samaritan was a voluntary worker, unofficial, neither levite nor pharisee. The immediate object of the hospital, like that of early medicine, was relief of the individual sufferer. This outlook largely continues.

Now that the nation has shouldered the wide responsibility of both treatment and prevention, a reorientation

of medical provision is necessary. The supply of hospital beds for persons who are seriously sick and in need of skilled care must be adequate in extent and fair in distribution throughout the country. But if hospitals are to have effective value in the larger field of prevention, there must be developed fuller possibilities for scientific investigation, and a completer follow-up service in relation to individual patients and their environment. The significance of this last point was pressed by me conspicuously in relation to tuberculosis, and formed a main plank in the programme of the tuberculosis dispensary as originally conceived forty years ago. As to its value when properly conducted, there cannot be two opinions. The difficulty lies in the co-ordination of effective agencies.

The natural agent in the follow-up is the family doctor, whether private or panel practitioner. In proportion as he is able to develop the preventive outlook, things will go well. When such natural provision is absent, or insufficient, there falls to someone else the delicate task of projecting the benefit obtained in hospital throughout the life of the patient at home and at work. This has become the field of the almoner or health visitor. Satisfactory fulfilment of the mission calls for wisdom and prudence in high degree. Within the field there are rich opportunities for scientific and social investigation.

In addition to the extension of service rendered by the individual hospital, there is great need to link up and co-ordinate the various types of hospitals. The different elements in the hospital network must be more or less united—loyal to the common cause and to each other. The élite within the group must lay less stress on *amour propre* and more on *esprit de corps*: *Noblesse oblige*. The better equipped hospitals and medical schools might do much to help smaller institutions and the great body of practitioners by sending out members of the staffs to co-operate with, and keep up to date, men who are stationed in the periphery.

The attitude of the Central Health Authority to the hospital question should be: Give us assurance that an adequate number of beds is available for the needs of the country, and that these are justly distributed in respect of the various areas and the various groups of diseases, and that their links with each other and with ancillary services are sufficient; it matters not to us whether the hospitals are maintained by voluntary effort or by the rates, or by such other machinery as may be found serviceable to the end. The fundamental requirement is that the Central Health Authority should have guarantee from the Local Authority that the provision of beds is adequate to the needs of its area, and that a jealous outlook is maintained in the direction of prevention.

Unification of Command.

As a preliminary to this, it is essential that responsibilities and powers relating to everything that concerns national health be vested centrally in one supreme Health Authority in the several portions of the kingdom, and peripherally in the various Local Health Authorities acting under the Central Authority towards the common end. This means the inclusion in the Department of Health of a number of activities which are presently outwith the department. The exclusion hampers procedure and development. Thus, in respect of hospital accommodation, there is everything to be said for the transference to the Health Department of the responsibility for medical treatment and care which is presently exercised by Poor Law authorities. All hospitals for the treatment of the sick should be included as component parts of a more or less uniform system applicable throughout the country. The legend over the door of the Royal Infirmary of Edinburgh—*Patet omnibus*—must inspire the nation's policy in matters of health. The advantages that would accrue to such transfer and combination are obvious in respect of the output of the collective group of hospitals, whether we consider that in terms of the treatment of the sick, the training of students and nurses, or the advance of medicine by observation and research. Let us hope that within a very short time the rearrangement will be secured by Act of Parliament.

Economic Alignment.

In connexion with the provision of hospitals, it is to be borne in mind that, in proportion as the preventive attitude is assumed by the medical profession, unofficial as well as official, the need for certain classes of hospital will grow less. This will bring economic advantage. Thus, when the truth of the dictum comes to be adequately accepted that "the tuberculosis of a people begins in the nursery and school room, and that it is to the nursery and school room that observation and effort must be directed if measures for the eradication of tuberculosis are to be fundamentally sound and practically effective," the need for the provision of hospitals for advanced stages of visceral disease and for crippled frames will progressively diminish. The time will come when hospitals for advanced disease and settlements for tuberculous wrecks will be regarded as anachronisms. In proportion as it is recognized that tuberculosis may be prevented or, at least, that the worser consequence of infection may be anticipated and averted, the scheme of remedial institutions which are immediately necessary because of the ignorance and neglect of the past will undergo progressive modification and curtailment.

With widening vision regarding hospital and ancillary services the relation between different sections of the profession will become simpler. Attachment to hospital and other medical institutions will become more general in the medical ranks. The medical corps throughout the land—official and unofficial—will be welded by the common aim to conserve the health of the nation. The result of the effort will depend ultimately on the general practitioner. It is to the family doctor, who is the effective embodiment of the spirit of the profession, that the nation must look for the development of the turning movement towards health. The family doctor, to whom the home in all its health interests should be no less open than the sick room, can contribute most to complete the success of the new strategy. The resources of medicine must be pooled. If there be community of purpose and knowledge, the tactics of the new advance are not beyond the wit and power of the profession. It is up to each arm to do its part.

Eighty-seven years ago Charles Wilson, a Scottish country practitioner, summed up the results of his observations on the health of the labouring population of the border town of Kelso as follows:

> "When man shall be brought to acknowledge (as truth must finally constrain him to acknowledge) that it is by his own hand, through his neglect of a few obvious rules, that the seeds of disease are most lavishly sown within his frame and diffused over communities; when he shall have required of medical science to occupy itself rather with the prevention of maladies than with their cure; when Governments shall be induced to consider the preservation of a nation's health an object as important as the promotion of its commerce or the maintenance of its conquests, we may hope then to see the approach of those times when, after a life spent almost without sickness, we shall close the term of an unharassed existence by a peaceful euthanasia."

Most remarkable words, you will agree with me, for the year of grace 1840.

Intelligence Department.

The ordinary citizen needs to be educated. He is even now clamouring for knowledge. The lesson of health should begin in the school. Having regard to the marvellous heritage of health to which most individuals fall heirs at birth, it seems incredible that no systematic attempt has been made to instruct the entrant into life regarding its preservation. We must press for the more general inclusion within ordinary school teaching of training in the principles of health—*not* instruction regarding disease or a system of hygiene. What we want to ensure is, that the growing individual has a working knowledge of the make-up of his own body and its functions, and can appreciate beauty of form and know when smooth activity is disturbed. He must get to understand the close dependence of health on environment. The recent appointment at one of our public schools of a doctor as head master is an interesting experiment in the forward direction which seems to me commendable. The result will be followed with interest. It remains to be seen how the doctor compares with the clergyman and with the scholar in charge of

developing boys. With youth sensibly trained about the machine which is peculiarly his own, it may be anticipated that within a generation the attitude of the nation to health questions will be completely changed.

Meantime, existing ignorance and post-war restlessness must be faced. There is need of popular education in the wider sense, and the dissemination of sound knowledge regarding health and the factors which make for disease. It must be insistently urged that, *the causes of disease being withdrawn, health is restored.*

To avoid the difficulties and pitfalls attendant on sporadic propaganda by individual members of the profession there should be an ordered attempt to use legitimate means to achieve the purpose. Medicine must roll out "the song seraphically free of taint of personality." Why should not the British Medical Association, through its network of Branches, serve as chief voice? Within recent times the Council of the Association has been consulted by, and has been accorded entrée to, the Ministry of Health regarding debatable subjects. Why should not each Branch similarly form an accredited medium of communication with the corresponding local authority by means of reports on matters affecting the health of the area, and with the larger public by the press, through authoritative contributions on questions of living interest? The press is a great educator; *the university of the man in the street.* Medicine must court its alliance and contribute her best to abet its efforts.

I have long pleaded that, as part of the local machinery of health administration in each sufficiently large area, an advisory medical committee should be erected which would be available to the local health committee and to the medical officer of health for consultation and guidance. The arrangement would constitute a tactical procedure of much importance on the present strategic front. It would have permanent and growing value as compared with the occasional lecture which, like a brilliant firework, is apt to vanish in smoke.

Other natural channels suggest themselves as serviceable towards the common end. I would name especially the branches of the British Red Cross Society, which, in virtue of the Supplemental Charter granted by King George V on December 12th, 1919, includes among "its objects and purposes" the "improvement of health and the prevention of disease." Similarly the Scout and Guide movements are pregnant with promise for the future of the race.

Munus Apolline Dignum.

The quest of health for the world is a great adventure. It is up to Medicine to lead the way and sustain the brunt of front line combat. If Medicine step into the breach she will recover her place of direction in matters affecting the human machine and national policy relative thereto, as these affect education, housing, industrial life, town planning, etc. Medicine is too apt to remain passive and silent in presence of issues which touch her vitally. She must free herself from the reproach implied in the poet's words: "*Mussabat tacito Medicina timore.*" If Medicine is to remain worthy of her divine origin she must flash the light from the car of Phoebus. Medicine must anticipate, inspire, and guide policy, and not rest content merely to carry out instructions imposed on her. Her chartered institutions, Colleges, Faculties, this powerful Association, and other collective groups, must not limit themselves as they commonly do to criticisms of proposals which reach them from without, and to grumbling at the terms of statute and regulation to which they are asked to conform. They must envisage and mould the developments of the future.

The aspirations of Medicine are not limited by geographical boundary or national policy. The study of health as a department of the science of life leads its devotees to observations and investigations in every clime. Nothing that influences human life is foreign to its purview. With mankind as its sphere, its aims and relations are world-wide. They are frankly international. Concerned with matters common to the race, Medicine will add to its triumphs in proportion as combination and collaboration of forces is secured throughout the globe. Towards this end much may be expected from fuller collation of the findings of individual workers and scattered groups in different countries—for example, by authoritative reports and conferences such as have been fostered by international associations, the League of Red Cross Societies, and the Health Bureau of the League of Nations. This widening evolution of medicine cannot fail to weave bonds making for solidarity among the nations. Already the tropics have been made habitable, and success in the completer adaptation of the planet for the life and health of man is only a matter of time.

Of all the attributes attaching to Medicine since the days of Hippocrates none has carried her further than her self-forgetting humanity. She is "humble because of knowledge, mighty by sacrifice." *Pace* the cynic, without the camp, and within it, that quality has inspired, and continues to inspire, her greatest adventures. With mind and eye fixed on perfection of form and function as the ultimate goal, the doctor's increasing purpose as the years roll on is the physical betterment of the race. We read that in the beginning man was created in the image of God, and that the Creator breathed into his nostrils the breath of life, and that he was placed in the Garden of Eden. Those biological attributes and relationships Medicine must recapture for mankind.

SOME REMARKS ON OUR PRESENT HOSPITAL SYSTEM.*

BY

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[AFTER a description of a motor tour through France and Spain to attend the meeting of the (British) Chirurgical Club in Madrid shortly after Easter, and a brief account of what the members saw, including some details of the working of the institution for the treatment and re-education of injured workmen, Professor Hey Groves continued as follows.]

It is the fashion now for all speakers and writers on our present hospital system to begin by assuming that there is something sacrosanct about the voluntary hospital system, and that it is our first duty to save this at all costs. Now I would begin by challenging the truth of this assumption. I should like to say boldly that the voluntary hospital system is dead. For there is something dignified and final about death—an honoured memory—a solemn requiem and a fitting monument and memorial. But unhappily there is neither dignity nor finality about the present condition. The system is not dead, but moribund, and its laboured life is kept going by stimulants and artificial respiration. Originally, and up to the beginning of the present generation, it may fairly be claimed that the voluntary hospital system did fully meet the needs of the time, and that it compared very favourably with the hospital system of any foreign country. In those days the situation was very much simpler than at present. It was only necessary to provide board, lodging, and nursing for the sick, with provision for emergencies such as surgical operations, which were then quite infrequent. The treatment of severe illness in those days was largely expectant, and the medical men who undertook hospital practice were the ordinary general practitioners of the town.

When I was a student there was only one general operating theatre at St. Bartholomew's Hospital, and at the General Hospital here in Bristol all the routine operations were performed on one afternoon in the week, the various members of the staff operating in turn with the others as spectators. Again, in those old days the voluntary hospitals were the only places where collective study and treatment of disease was undertaken. If a person had a comfortable home of his own then in times of sickness he stayed at home, and either medical or surgical treatment was carried out there. Treatment was so simple that everything needful could be done in a patient's own house. The hospital originally was

*Being the presidential address delivered to the Bath and Bristol Branch of the British Medical Association at the Bristol University, June, 1927.

merely a home for the sick poor, where they could be lodged and fed at a time when their earnings had ceased, where the doctor visited them and prescribed for them, and the nurse washed them and made their beds. But what a change has come over things in the last thirty years! Anaesthetics and antiseptics have made surgical treatment available for considerably more than half of all cases of serious illness; *x* rays have rendered it possible to make diagnosis and prognosis certain in many cases where formerly these were only guesswork. The clinical laboratory has been evolved, and it is now no exaggeration to say that the examination and treatment of sick people is an exact scientific process, requiring the collaboration of many highly trained persons. This is true also of the new application of existing knowledge to cases of current disease or accident; but, in addition to such routine application of methods, there has come to be a realization of the need for more knowledge.

In former days the idea of new discoveries was left to the irrepressible genius of exceptional men such as Hunter, Pasteur, or Lister. But in the new spirit of our age almost every young man who has achieved a position on a hospital staff cherishes the conscious or unconscious ambition to find out and hand down to his successors some new thing, some better treatment, or to write some new page in the history of medical achievement; so that to the immense advance in methods of examination and treatment of the sick there has been added to the responsibilities of our institutions the glorious possibilities of research.

In a word, the hospital, which began as a mere hostel for the sick poor, has now to be a laboratory for scientific work, for prevention, diagnosis, cure, and discovery. The beneficent value of this work is now so generally recognized that the portals of the hospital have had to be opened to admit not only the indigent poor, but the middle class and the well-to-do. Still, however, there is not room, and there have had to be provided nursing homes for the wealthy and enormous municipal hospitals for the poor, so as to cope in a rather inadequate fashion with the problem which has become too vast for the voluntary hospitals.

It will be instructive if for a moment we compare the problem of education with that of hospital service. Until nearly sixty years ago education was also almost entirely voluntary. It was provided for by the charitable and religious bodies, who collected money for the building of schools and the payment of teachers; but growth of knowledge and the urgent need of imparting knowledge to all children soon made it impossible for the system to continue. In 1870 an Education Act was passed, by which the State undertook the responsibility of primary universal education, and since that time secondary and university education have to some extent become also a charge upon the State. This has not prevented religious bodies and private endowments from taking a great and honourable share in education; but the State, having set the standard and provided the means for education, this essential service is satisfactorily secured for all time and is no longer dependent upon philanthropy or mendicancy. Is there anyone who regrets this change from voluntary to State education? Should we like to think that the education which is essential for the community is to be dependent upon charity of the rich, upon the street corner collections, upon the results of pulpit appeals and well advertised lotteries? Would it content us if most of our schools were imperfect in size and structure and below the standard of Continental schools, simply because we could proudly boast that our education system was voluntary? Yet this is exactly the position of the equally essential hospital service in this country to-day

Many of our voluntary hospitals are out-of-date old buildings, badly placed in unsuitable sites. It is true that most of such old buildings have been supplemented by newer wings of better design, which serve by contrast to show up the badness of the old part of the structure. The hospital sites and buildings are second or third rate as compared with the standard of modern buildings found in most foreign teaching hospitals. The buildings are not only below standard, but they are inadequate in regard to size. In our big cities the voluntary hospitals have not kept pace with the growth of the population or the increasing demand for hospital treatment made by a larger proportion of the citizens. The lists of patients waiting for admission are becoming longer, and the municipal and Poor Law authorities are forced to build hospitals to meet the need.

In our own city the need for hospital beds has more than trebled in the last twenty years. This need has been met by the voluntary hospitals increasing from about 400 to 700 beds and by the municipal and Poor Law hospitals having been advanced from 100 to nearly 1,000.

From this it is evident that the voluntary hospitals now only take a second place in regard to the number of beds provided. But there is still a more serious aspect in this indictment of the voluntary system. Each voluntary hospital has its origin in the bequest of some benefactor or group of benefactors. The Royal Infirmary here was started by Churchmen and Tories, the General Hospital by Nonconformists and Radicals; Kingswood Hospital by the generosity of Mr. Handel Cossham and the fortunate circumstances which greatly increased the value of his gift after his death; the Children's Hospital, Eye Hospital, Orthopaedic Hospital, and Homoeopathic Hospital were each originated by philanthropists, whose names and memories are honoured in our midst.

Each hospital thus founded is an independent unit, governed by its own constitution, depending for its support partly on endowment, partly on an appeal for public assistance. This might be all very well if funds were adequate for the purpose and if the provision of a hospital service merely consisted in having bed, food, nursing, and a bottle of medicine for each sick person. It is, however, anything but well when funds are so inadequate that about half those requiring hospital treatment have to be handed over to the Poor Law or municipal authorities, and when the diagnosis and treatment of disease have become highly specialized sciences, requiring operating theatres, *x*-ray plant, laboratories, and, above all, highly trained specialists, who can only give first-rate service in a small part of the healing art. If it is true that under the present system there is not money enough to make any one hospital in this city perfect, it is still more obvious that each hospital cannot secure a perfect team of specialists, or provide such a team with a proper equipment or an adequate field for training, experience, and research. Take, for example, the subject of the prevention and correction of deformities, or orthopaedic surgery in the larger meaning of the term. No one will deny the importance of this subject from a scientific or industrial point of view; and yet among all the hospitals of this city there is not one which is large enough to provide an orthopaedic department.

Some years ago members of the staffs of the two larger hospitals in Bristol formulated a scheme for an orthopaedic institute which should be common to both, but this was not favoured by the managing bodies of either hospital, because, I suppose, it would have added to the individual lustre of neither.

Surely we know, and the general public will admit, that medical science is a highly complex affair, requiring special buildings and a highly trained staff. If this is so, ought there not to be an authoritative body which should regulate the standards of hospital site, hospital construction, and hospital staff? Such a central hospital board would be comparable in its composition and functions to the education committee, and would do the same for hospital service as the latter does for teaching.

As a matter of fact the need for expert direction of hospital affairs is very much greater than in education, for the science of healing has become so much more complex than that of primary or even secondary education. The grading of teachers and of schools is much simpler than that of hospitals, surgeons, physicians, and specialists.

The case for a co-ordinated hospital system depends, then, very largely upon the necessity for specialization in medical treatment and research. There is no need to argue as to this necessity, because it has been admitted and put into practice. Even "the man in the street" knows that he cannot get the best advice for his eyes, or ears,

or heart, or brain unless he goes to a doctor with special experience, and one who has that experience and practice in a modern hospital.

Granted, then, that specialization is a necessity, it would follow that special departments should be made as perfect as possible. To get this perfection unification is essential in order to obtain the best administrative control and to economize in the provision of costly apparatus and the still more priceless skill of experienced men. My meaning may be made clearer by examples.

Some years ago it was recognized that venereal disease should receive special study and treatment. This was partly because of social reasons, but also because new methods of treatment had been elaborated which required apparatus, administrative control, and specially trained men. The Government took the matter up and began by utilizing the staff and accommodation of existing large hospitals; but within a very few years this plan was replaced in large centres like Bristol by a single centre under one man, who has control of staff and assistants. This clearly shows that any authority that has responsibility in hospital matters would unify special departments to get maximum efficiency.

Next consider the problem of cancer research. This is a highly specialized subject and there are very few who are competent to undertake it. We are fortunate in Bristol in having Dr. Todd, who has already demonstrated his knowledge, enthusiasm, and a fair promise of success. For the purpose of his work he requires laboratories and assistants and ample financial support. Other institutions cannot afford to create similar departments, and even if they could, they cannot obtain another Dr. Todd by the simple expedient of advertising for him. Therefore I say that if such a department as that for cancer research can be founded in this city it should be placed in a unified hospital system so as to make it available for all.

Radiotherapy is perhaps the best example of a special department which requires a large initial outlay in material and apparatus.

The General Hospital has secured from a generous benefactor £5,000 worth of radium, and probably £20,000 worth will be required to do the work similar to that which is now carried on in London and Manchester. If and when this is obtained it ought to be available for the whole city and those districts which look to Bristol as their health centre; and not only ought this expensive plant to be common to the Bristol hospital system, but the one or two men who use it should have all the office work for record keeping and following up results under a single control. Be it noted, then, that the lead-selenium treatment of malignant growth which the infirmary is providing, and the radium with which the hospital is endowed, are both intended for the same object—namely, the cure of cancer. Under the present system these two potent agencies have been placed at different institutions—the only connexion between which is their rivalry, and whose most cherished tradition still is that no member of the staff shall serve both.

I have already spoken of orthopaedics, and mentioned that in the opinion of the surgeons of Bristol an orthopaedic department is very urgently needed; but none of the existing hospitals have a large enough surgical service to justify setting aside the necessary number of beds for the purpose. It is quite safe to predict that if the hospital system was unified, such an orthopaedic department would be founded at once.

Our present hospital system is radically wrong. It is wrong because it consists of isolated units without public control. No one hospital unit is perfect or self-contained, and there exists no co-ordination between the units by which the deficiencies of one may be made good by provision in another. No financial assistance of the voluntary hospitals can make good this radical defect, unless such assistance is accompanied by a condition for unification under a central control.

At present the hope for a better state of things seems to me to lie in the insolvent conditions of voluntary hospitals. The managing bodies of these institutions have now to choose between one of two policies: either they spend what is necessary and accumulate a big debt, and when this becomes impressively large they make a heartrending appeal to the public to "Save our hospitals," or they practise rigid economy, and whilst they avoid a big debt they allow the institution to become inadequate for the work it has to do. At the same time patients are asked to pay towards the cost of their maintenance, collections are made in churches and in the streets, students are encouraged to practise buffoonery and mendicancy in public, lotteries, and even a mild form of blackmail are allowed to keep alive a system which in itself is essentially wrong. Instead of preaching in our church pulpits to ask for money for this system members of the British Medical Association would do well if they were boldly to declare that every penny given to the voluntary hospitals does something to prevent this city or country getting a proper hospital system.

Frankly, my first object in this address is iconoclastic. I would do all in my power to break the false gods which we have been taught to worship. So long as the voluntary system is kept alive we shall never have a co-ordinated hospital service. Every idol breaker is inspired by an ideal, and this is certainly so in my case. In Bristol we have every condition necessary for realizing such an ideal and of giving a lead to the whole country. A compact and wealthy city of nearly half a million people, surrounded by glorious country within easy access, a magnificent university, and the tradition of being the spot from which men stepped off for the discovery of a new world!

The ideal in my mind is to have, in the first place, a central board of hospital management concerned only in matters of general policy. It would determine what hospital provision was necessary; no philanthropist would be allowed to start a new hospital without due regard to the needs of the community. It would decide what special departments were needed, and where they should be placed. It would be ruthless in destruction of old or badly constructed and badly situated hospitals. Its main concern would be the provision of one large first-grade hospital, or hospital groups in which the study and the treatment of disease in all its special branches could be carried out with the maximum of efficiency and economy in regard to buildings, administration, equipment, and personnel. It would decide what ancillary hospitals were needed for special cases which require isolation.

The principal unit in the hospital system should be of such a size as to admit all cases of disease requiring institutional treatment (other than those needing isolation). This would involve a hospital of 1,000 beds. It would be built in the pavilion system, so as to contain, say, 800 beds at first, and be capable of extension to 1,000 or 1,200 as need arose. The hospital site would be in the country, within easy reach of the city. There would be main departments of medicine, surgery, and gynaecology with midwifery of 200 to 300 beds each. The medical department would contain such special departments—for example, those for cardiology, dermatology, pulmonary disease, or neurology; the surgical, those for orthopaedics, urology, cancer research, and radiology—as might be deemed necessary. There would be special departments for ophthalmology, oto-rhino-laryngology, of about 50 beds each. Every department would contain private wards for patients who could pay full fees for maintenance and professional attendance. All members of the staff engaged in teaching and research—and this would include all heads of departments—would be appointed and controlled by the university.

The question as to the payment of the staff, whether they should be paid at all, and, if so, how much, and by whom, is complex and perhaps of secondary importance. On one aspect of the case, however, I am quite clear: every department of the hospital should have as many junior assistants as it can find use for, their work being teaching and research and assisting in clinical work. These junior assistants should be paid a reasonable salary—that is, £400 to £700 a year, according to their time of service. Only in this way will it be possible to get the largest number of the best men from whom to choose the full staff of the hospital. Our present system makes no provision for the financial maintenance of prospective candidates for junior posts on the staff, nor indeed for the junior members of

the staff themselves. The result is that these posts are only open to men who have private means, or to those who have to make a living by private practice or coaching. We lose, therefore, many good men, and those we get become quickly absorbed in earning their living and cannot devote themselves to academic work.

The central hospital board would also have under its direction a group of ancillary hospitals—for example, those for infectious diseases, venereal disease and mental disease, and chronic or incurable disease for which only palliative treatment is possible; chronic crippling disease for which an open-air school hospital is needed. Such hospitals, of course, already exist, but they are controlled now by independent bodies without any definite relation to one another. Further, there would have to be a group of treatment stations for casualties and out-patients. These would be in close administrative association with the central hospital and would be staffed by the junior members of that institution.

Finally, no scheme would be complete which did not make some provision for the co-ordination of outlying country hospitals. I am quite aware that this opens up a very big subject and one which might well occupy the whole of an evening's address. But it is evident that if my main contention is correct—namely, that the treatment of disease should be organized on scientific lines—then there is no more justification for leaving the problem to be solved by haphazard philanthropy in the country than in the towns.

The need for, and the size, scope, and staff of a hospital in any country town or village should be much more a matter for Government control than the similar problems in relation to public-houses, music-halls, or schools. Every country hospital should be linked up with the university hospital in such a way that cases requiring special observation or treatment can be drafted from one to the other, and there should be an arrangement by which specialists from the university hospital could be available for consultation at the country hospitals. Further, the junior men, trained at the university hospital, all of whom cannot be absorbed by its staff, should have the opportunity of taking positions in the country hospitals, where they would work in amicable relations with their former chiefs.

This, in broad outline, is the ideal towards which we, in my opinion, ought to strive; the great obstacle in the way of the first step towards its attainment is the false notion as to the excellence and sanctity of the voluntary system.

It is generally assumed that lack of money is the main difficulty. I do not believe this for one moment. If the profession stood four-square and told the country that our hospital system of independent competing units was essentially bad and that there was urgent need for reform, then the money would be forthcoming just as readily as it was for education or the national insurance scheme.

As a striking comment upon the idea that a lack of money prevents adequate hospital provision and equipment, let me draw your attention to the fact that recently the city council has passed a scheme for spending one-quarter of a million pounds for the provision of accommodation for feeble-minded children!

During the last five years a voluntary committee has been trying to make provision for an open-air school-hospital for crippled children suffering from curable complaints, and has at last succeeded in getting the miserably inadequate sum of £20,000, with which, and with splendid optimism, it proposes to begin the work. The quarter of a million scheme for mental defectives was arranged by a gentleman who is also chairman of our largest voluntary hospital committee, a committee which is trying to pay its debts by selling half-crown lottery tickets for motor cars.

In this city there appears to be no financial difficulty in providing for the sick if these are criminals, lunatics, feeble-minded, or the subjects of venereal disease. But if the sick are intelligent, respectable people, suffering from cancer, appendicitis, or the results of street accidents, then they must be dependent upon a weary and flagging charity, supplemented by money-making methods which for any other purpose would be considered illegal.

In fact, State-aided insurance would seem to be the obvious solution of the financial difficulty.

Capital outlay on building new hospitals would not be as great as might be supposed. When unnecessary hospitals had been disposed of and sites sold there would be money enough to do a great deal of reconstruction, and this would have to be supplemented by a municipal rate and county rate, to which the State would contribute an equal amount.

THE VIRULENCE OF PNEUMOCOCCI IN PNEUMONIA.*

BY

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IT is generally agreed that, though pneumococci are the commonest bacterial cause of pneumonia, these organisms also occur in the throats of a large proportion of healthy persons, who may never contract pneumonia. Why the pneumococcus should in the one case set up a highly dangerous condition, and in the other give rise to no ill effect, is unknown. The phenomenon is explained in such general terms as "variations in the resistance of different hosts" and "variations in pathogenic power of the micro-organism." Little is known of either of these factors, but investigations on the virulence of pneumococci obtained from all kinds of lesions, including many cases of pneumonia, offer certain clues for the solution of the problem. I have found that there are wide variations in pathogenic power among different strains of pneumococci, which I think explain some of the facts.

A measure of pathogenicity was first obtained, in terms of the minimal lethal dose for mice. The virulence measured thus was determined for each of sixty strains of pneumococci, collected at random, forty of which were isolated from pulmonary lesions, and the rest from lesions in other parts of the body chiefly secondary to pulmonary lesions. The series exhibits a very wide range of virulence, and the strains are conveniently classified into groups according to their grade of virulence.

These grades correspond quite constantly to different forms of disease in the lung. The highest grade is associated with the most acute, the most clearly defined, and the most fatal form of pneumococcal infection of the lung—namely, lobar pneumonia. The next grade, only slightly lower, is associated with bronchopneumonia, a less acute, less regular, and less fatal type. Empyema, which may arise from the extension of either a lobar or bronchopneumonic type of lesion to the pleura, corresponds to a range of virulence covered by both types. A sharp and unexpected fall in the virulence occurs before the next class is reached. This class is represented by terminal pneumonia, post-operative pneumonia, and such lung conditions as frequently arise in patients suffering from advanced disease or shock.

Pneumococci may therefore be divided into at least two groups by virtue of their pathogenic power; those of high virulence setting up well recognized clinical entities like lobar and bronchopneumonia; and those of low virulence which are associated with minor illnesses, or disease occurring in persons already debilitated.

The organisms of the first group are probably spread by contact, much as cerebro-spinal meningitis is spread, with only a small percentage of "contacts" contracting the disease. An outbreak of epidemic proportions at Cottenham, a village in Cambridgeshire, resulting in twenty-six cases of typical lobar pneumonia, affords convincing evidence of this method of spread. From every case examined a highly virulent Type I pneumococcus was isolated, and the spread of infection was traced from house to house and person to person. A similar outbreak on a smaller scale occurred at Cavendish in Suffolk, and no doubt other similar outbreaks could be traced if a search were made.

The second group, consisting of pneumococci of low

* Report to the Science Committee of the British Medical Association, June, 1927.

virulence, cause illness only under exceptional circumstances, and their effect is less specific and less typical. They are more akin in their behaviour to such relatively harmless organisms as the *Streptococcus salivarius*, which they closely resemble; either may give rise to similar lesions under similar conditions, and without tendency to virulent epidemic spread.

The American classification of pneumococci into four types, according to their serum reactions, has been found of no value for determining the pathogenicity of a strain. The idea that the three specific types—I, II, and III—might represent the virulent, disease-producing strains, and Group IV the avirulent, has not been borne out as the result of these experiments, though Group IV certainly contains a bigger proportion of avirulent strains than any of the other groups. The typing classification may be useful, in conjunction with virulence tests, for tracing a definite strain through an epidemic, but the virulence test furnishes the only reliable means of ascertaining the power of the strain to produce infectious disease of the lung.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

DERMATITIS EXFOLIATIVA.

THE following case presents several features of interest, and is thought worthy of publication.

On December 12th, 1926, a motor mechanic, aged 19, was admitted to West Lane Hospital, Middlesbrough, with the diagnosis of scarlet fever. There was a history of generalized pains, shivering, and sore throat beginning on December 7th, the onset being gradual. He vomited on December 10th.

The patient's condition was one for anxiety. He looked ill; the temperature was 103° F., pulse 120, respirations 24. A coarse scarlatiniform punctate rash involved the face, neck, trunk, and upper and lower extremities. The circumoral area was also invaded. The fauces were very congested. The tonsils had been removed some years previously. There was no discharge from the eyes, ears, or nose. The tongue was covered with a thick white fur. The epitrochlear glands were enlarged, but not those in the cervical region. He was constipated. The urine, of amber colour, was cloudy, with a specific gravity of 1029; it contained urates in quantity, but there was no evidence of albumin or sugar. He had a slight cough, but physical examination of the chest was negative.

On December 14th jaundice was observed, and the skin had a peculiar greenish hue. Scaling had already begun. The abdomen was prominent and tympanitic, but there was no evidence of enlargement of the liver or spleen. No tenderness could be elicited in any area.

On December 17th both ears began to discharge, and on the following day a purulent exudate from the eyes was seen. The conjunctivae were lemon yellow. A bright yellow purulent discharge exuded from the skin of the face, and small pustules appeared on the buttocks and legs. During this period heavy desquamation of the skin continued, but the jaundice gradually disappeared.

Some of the septic spots, which by December 25th had spread over the whole body, now became larger, and an abscess appeared over the lower dorsal region. This was opened, and on January 12th, 1927, a large abscess in the left inguinal region was incised, and on the following day another was evacuated on the outer aspect of the left knee. Twenty-four hours later pus was drained from two abscesses, one on the face, the other on the right arm.

On January 17th a coarse punctate rash appeared on the face, neck, chest, and upper extremities. It was septic in character, but disappeared in thirty-six hours.

A week later the temperature, which had shown marked irregularities, returned to normal, and the patient's convalescence commenced. Pus continued to exude from hundreds of small openings in the skin of both lower extremities, but the discharge gradually ceased a dusky macule remaining to show where a skin lesion had previously existed. There was now no discharge from eyes or ears.

The patient left hospital on February 15th, well, and comparatively strong, except for slight arthritic changes in the interphalangeal joints of the toes, and marked alopecia.

Examination of the discharges from the skin showed the *Staphylococcus aureus* in abundance. An autogenous vaccine was prepared, and vaccine therapy resorted to on December 30th with an initial dose of 30 millions. Stannoxyl tablets, nine each day, were administered at the same time. Tonic treatment with quinine and iron was commenced at an early stage of the illness, and mild antiseptics were applied to the skin. Fluid diet was given for the first three weeks; it was then gradually supplemented until after a further three weeks the patient was on normal diet.

In this case there was no question of the malady being a sequel to psoriasis or seborrhoea corporis. Dermatitis herpetiformis, erythema multiforme, or lichen had no place in the patient's antecedent history. Tuberculosis, rheumatism, and gout were excluded so far as the etiology was concerned. Leukaemia and mycosis fungoides could both be differentiated, and there was no evidence of the administration of salvarsan. The Wassermann reaction was negative. The cause, in short, appeared unknown.

The outstanding points of difference from the usual case were the presence of exudate from skin and mucous membranes, and the appearance of jaundice. Undoubtedly a toxic influence was at work, most probably of intestinal origin.

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ACUTE APPENDICITIS COMPLICATING TUBERCULOUS ASCITES.

THE following case presented problems in regard to diagnosis and to pathology which I think make it worthy of record.

A girl, aged 15, had been in poor health for some months, and for several weeks had suffered from vague abdominal pains. She was taken suddenly ill on May 4th, 1927. In the afternoon she vomited, and soon afterwards experienced intense pain in the abdomen. It was not localized, but was accompanied by vomiting, which continued throughout the night. On the following day she was admitted to the North Lonsdale Hospital, Barrow-in-Furness.

On admission the patient looked extremely ill; temperature 103°, pulse 140, respirations 20. The tongue was furred, and no motion or flatus had been passed for twenty-four hours. The acute abdominal pain had suddenly subsided two hours previous to admission. The abdomen did not move on respiration, and was uniformly distended. The umbilicus was slightly protuberant. On palpation the whole abdomen was tense, and a fluid thrill was easily elicited. The left side was not rigidly guarded, but the right side, particularly the lower area, was more definitely rigid. The patient had passed urine, and the catheter drew off only a small quantity.

In seeking a diagnosis the following conditions came under consideration: (1) ovarian cyst, with torsion of pedicle; (2) tuberculous peritonitis, with acute exacerbation; (3) perforation of the appendix, or of an intestinal ulcer, with diffuse peritonitis.

Operation.

On May 5th, under ether anaesthesia, the abdomen was opened through the right rectus sheath, and on excising the thickened peritoneum a large amount (about 180 oz.) of straw-coloured clear fluid escaped. The peritoneum and intestine showed typical tuberculous nodules studded in large number. The caecum was intensely injected, and thick lymphy exudate covered its surface. On freeing this area a gangrenous appendix was found, retrocaecal in position, and perforated about its middle. The appendix was removed, and with some difficulty the stump was invaginated. The abdomen was closed, and drainage to the caecal region and pelvis provided.

For several days pus was discharged from the tube, and later a part of the wound gave way and pus escaped. The discharge gradually cleared up, and the further progress was uneventful.

From the pathological point of view it is submitted that the two conditions found were coincidental, the suppurative appendix lesion being added to the well established tuberculous ascites. An alternative theory is that possibly a tuberculous lesion of the appendix may have interfered with the emptying of the lumen, and thus caused acute empyema or necrosis. Further investigation was impossible as the appendix was too much altered to permit of microscopical examination.

A point of added interest is in regard to the manner in which the peritoneum, altered by tuberculous changes, becomes highly resistant to pyogenic infections. The effect of the peritonitis, with its intense reaction, and of the laparotomy has been most marked, and the ascites has completely disappeared. This may be regarded as an illustration of the conclusions of Hildebrandt, who has described the occurrence of post-operative hyperaemia, even in cases of uncomplicated tuberculous ascites, and who considers that a plastic outpouring around the tuberculous nodules results in their cure by encapsulation with fibrous tissue.

I have to thank Dr. W. S. Shearer and Dr. Dorothy Stewart, house-surgeons, for their valuable assistance.

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OXFORD OPHTHALMOLOGICAL CONGRESS.

THE seventeenth annual meeting of the Oxford Ophthalmological Congress was held at Oxford on July 7th, 8th, and 9th, under the mastership of Mr. Philip H. Adams. The proceedings were held in the Department of Human Anatomy, through the kindness of Professor Arthur Thomson, whilst Keble College, where members met informally at dinner on July 6th, again afforded hospitality.

OPERATIVE TREATMENT OF GLAUCOMA.

After a brief address by the MASTER, a discussion on the results of the operative treatment of glaucoma was opened by Dr. WILLIAM H. WILMER, ophthalmologist-in-chief to the Johns Hopkins Hospital, Baltimore; he began with a reference to the work of von Graefe, who in 1857 wrote concerning glaucoma: "The absence of general agreement constitutes an hereditary evil of therapeutics only to be cured by slow degrees. . . . The only treatment from which relief can be expected is one that diminishes pressure." That both these propositions were true to-day was attested, Dr. Wilmer said, by the fact that over sixty operative procedures, with many modifications, are on record, all devised solely for the purpose of reducing intraocular tension. The following analysis of a few of the kinds of operations and their results as reported by various authors was presented.

Iridectomy.—482 cases; successful 63.3 per cent. No late infection mentioned.

Anterior Sclerectomy (Lagrange).—777 cases; successful 72.8 per cent. Late infection (based on 389 eyes) 1.3 per cent. Lagrange's own cases, 104; successful 85.5 per cent.

Sclero-Corneal Trephine (Elliot).—3,381 cases, not including 911 eyes operated upon in Egypt; successful 77.6 per cent. Late infection 1.2 per cent.

Punch (Holth).—Holth had published a record of 200 cases in Christiania from 1920 to 1923. The percentage of successes was not given, but he stated that there were no late infections, and concludes: "The lowering of the ocular pressure is as good as in the other forms of sclerectomy, and, so far, no case of late infection has been observed." Hagen had recorded 52 cases operated on by Holth, Hj. Schiötz, and himself. Of these he excluded 12, confining his tables to 40 cases of glaucoma simplex; successful 82 per cent. Butler had reported 29 cases; successful 79.3 per cent. Late infection 3.4 per cent. Later he reported 39 cases; successful 66.7 per cent.

Iris Incarceration.—517 cases: Iridotasis and iridencleisis; successful 87.4 per cent. Late infection 0.3 per cent.

Wedge Isolation and Small Flap Sclerotomy (Herbert).—The author had given up the former operation for the small flap sclerotomy. The reports were too few to analyse. Butler quoted 7 cases (small flap); successes 50 per cent.; but this in no way indicated the excellent results obtained by the skilful originator himself.

Cyclodialysis (Heine).—1,027 cases; successful 66.7 per cent.; no serious complications mentioned.

Dr. Wilmer said that while he employed iridectomy, anterior sclerectomy, and cyclodialysis, he used the trephine more frequently. Two series of his own trephine cases were then presented, several of which had been under his personal observation for many years.

Series I.—Of these 72 eyes 76.3 per cent. of the whole number have been under observation from ten to fifteen years; 19.4 per cent. from five to ten years; and 4.1 per cent. from three to five years. Successes 84.8 per cent.; failures 15.2 per cent.

Series II.—Thirty-five cases (private and free), trephined within two years (none within four months), are reported for comparison. Successful 91.3 per cent.; partial failure 5.7 per cent.; complete failure 2.8 per cent.

In these cases success meant a tension of 18 or under (Schiötz reading) with a maintenance or improvement of the vision and the fields of vision as compared with that before operation.

Causes of failure were previous venous thrombosis, tuberculous deposits filling trephine openings, traumatic dislocation of lens (ten years after a successful operation), rapid development of immature cataract after haemorrhage, and repeated retinal haemorrhages. In nineteen of the second series of cases Tenon's capsule implant was used, a valuable procedure where the conjunctival flap was too thin and as a prevention against late infection. A series of very interesting slides of the eyes of rabbits and dogs were shown, upon which anterior sclerectomy, sclero-corneal trephine, wedge isolation, small flap sclerotomy, and iridotasis had been performed. After commenting on the various types of operation, Dr. Wilmer said that every operator was more skilful in the performance of the operation he selected, but for the average the trephine operation was more safely and easily performed than the Lagrange or punch operation. It was suitable also for more kinds of glaucoma and in eyes with very high tension. In Lagrange's operation, if the pressure was high, there was more danger of expulsion of the lens and loss of vitreous at the time of the operation or later. Few operators had the skill of the originator of the excellent operation that bore his name. When the surgeon had so many cases requiring operation that he could perfect his technique in both the Lagrange and Elliot operations, the plan of several of Dr. Wilmer's colleagues was practical; that was to say, when the tension was below 35 (Schiötz) to perform anterior sclerectomy; when above, to trephine.

Professor FÉLIX LAGRANGE (Paris), who was accorded a very hearty reception, referred to the time when he performed his operation of sclerecto-iridectomy for the first time in England at the Oxford Meeting held in 1906, and commented on the cordial relationship ophthalmologically between France and England. With regard to results, he had never seen infection follow his operation.

Mr. A. L. WHITEHEAD (Leeds) said that after trying other procedures his rule now was to perform iridectomy in cases of acute glaucoma and trephining for chronic glaucoma. An analysis of 120 of his private cases, chosen because the records were more complete than in hospital cases, was as follows:

> Of 38 acute cases, 57.9 per cent. were successful, 26.3 per cent. partially so, and 15.7 per cent. were failures.
>
> Of 14 subacute cases, 85.7 per cent. were successful, 14.3 per cent. partially successful, and there were no complete failures.
>
> Of 48 chronic cases, 87.5 per cent. were successful, 4.1 per cent. partially so, and 8.3 per cent. failures.

Lieut.-Colonel H. HERBERT (Brighton) considered that successful results were obtained with his small flap operation, especially if massage was regularly applied afterwards. With regard to iris inclusion he thought a distinction should be made between disasters at the time of operation and simple failures to relieve tension; he felt that there ought to be no danger of sympathetic ophthalmia provided proper aseptic precautions were undertaken before the operation. His belief was that the future lay with the small linear wounds, either with or without iris inclusion.

Mr. MALCOLM HEPBURN (London) said that his operative experience had forced him to the conclusion that not all forms of glaucoma could be explained on the same pathological theory, but that different pathological conditions accounted for the various types of the disease. It followed that the results obtained by adopting one type of operation for all forms of glaucoma would be variable, and it was necessary for the surgeon to select the type of operation suitable for the case he had in hand. Good results would depend upon this and upon operating early; bad results upon operating late, unsuitability of operation, mistakes in technique, and secondary complications over which the surgeon had no control.

Lieut.-Colonel R. E. WRIGHT, I.M.S., agreed with Dr. Wilmer in his support of trephining as opposed to cyclodialysis. He was in favour also of a broad iridectomy in cases where he feared a "desquamation of uveal tissue," or "iritis," as it was termed. Massage was of value in all cases, although there was really no necessity for it after trephine operations.

Dr. C. F. BENTZEN (Copenhagen) reported the results of 72 cases of trephining in which he had separated the conjunctiva from the limbus instead of from above, as in the usual Elliot method. Of the 72 cases, 6 were of buphthalmia, 4 of acute glaucoma, 14 of absolute glaucoma, and 48 of chronic glaucoma. No case of late infection had occurred. The results were poor in the cases of buphthalmia, and also in those of absolute glaucoma. In the acute

cases the results were moderately good, and in the 48 cases of chronic glaucoma there were 77 per cent. of successes.

Professor SZYMANSKI (Wilna) described his modification of Elliot's operation, in which he made use of a large trephine to cut obliquely a semicircle of sclera which was then excised with scissors.

Mr. HARRISON BUTLER (Birmingham) mentioned the mental complications which happened in operations on elderly decrepit patients. In iridencleisis operations he had found that no result was obtained—that is, neither fall of tension nor an untoward complication. After trephining, a shallow anterior chamber might result which, if persistent, led to the formation of a nuclear cataract. He had observed the fall of tension in the fellow eye after a successful operation on the other.

Mr. DAVENPORT (London) referred to the analysis of some 536 cases of glaucoma, 405 being primary, which had been trephined at Moorfields by various surgeons in the last five years. The results obtained were recorded with regard to vision only. They were reported fully in the *British Journal of Ophthalmology* in 1926. In 2 cases only of the 536 did mental disturbance occur; there were 14 cases of late infection, of which, however, only 8 were definitely in connexion with the trephine hole.

Dr. HARALD GJESSING (Drammen) spoke of having had 81 per cent. of good results by Holth's method; the cases had been under observation from seven months to eleven years.

Mr. J. GRAY CLEGG (Manchester) considered that detachment of the choroid was a much more frequent result than usually believed—as much, in his opinion, as even 10 per cent.

Mr. B. GRAVES (London) referred to cases of persistent low tension after operation, in one of which shrinking of the eye had occurred.

Mr. D. V. GIRI (Eastbourne), in speaking of the fluorescine test for filtration, commented on the variations in tension which occurred during the day.

Lieut.-Colonel A. E. J. LISTER (Bristol) asked for an expression of opinion on the question of low tension after operation, which he regarded as a very alarming complication.

Dr. WILDER (Chicago) said that in America all operations had been tried, but no definite conclusions had been reached; this was good evidence that none was perfect. The best thing would be for one surgeon to perform all the various procedures for comparison. Personally he was in favour of the iris-inclusion operation, having only had one unsatisfactory case in 100 operated on by this method.

In his reply Dr. WILMER said that he had distinguished the cases with meticulous care, but out of sympathy for his audience had not read the whole. Expulsion of the lens after the Lagrange operation was, according to the literature, a not uncommon complication, and one such case had been recorded after a trephine operation. He had never experienced separation of the choroid in his own practice, but had seen two cases in consultation, both of which promptly got well. He had had cases of very low tension after both trephining and the Lagrange operation, but had never had an eye in which there was delayed formation of the anterior chamber.

Demonstrations.

In the afternoon of July 7th, after Professor F. LAGRANGE had read a paper on the best procedure to adopt for fistulization of the glaucomatous eye, demonstrations were held in the Scientific and Commercial Museums.

Lieut.-Colonel R. E. WRIGHT, I.M.S., demonstrated Green's apparatus in intracapsular extraction of cataract, and his own method of blocking the main trunk of the facial nerve to prevent squeezing in cataract operations. He also showed a series of extremely interesting histo-pathological slides of orbital neoplasms.

Dr. J. BURDON-COOPER (Bath) demonstrated a new astigmatic test chart.

Dr. THOMSON HENDERSON (Nottingham) demonstrated in an ox eye the membranous nature of the ligamentum zonulae lentis, by injecting air through the ligament into the canal of Petit, thus showing that it is a closed space.

Dr. H. H. TYSON (New York) exhibited a series of skiagrams of the optic foramen showing the variations in size and shape from the normal, and demonstrated the effect which the narrowing of the canal had upon the optic nerve, causing atrophy.

Mr. D. V. GIRI showed a photograph of a useful apparatus for red-free ophthalmoscopy and a lid retractor which raised the lids free from the globe as well as retracting them.

Mr. F. A. ANDERSON (Shrewsbury) exhibited an excellent operating light obtained by a series of small lamps.

Mr. B. CRIDLAND (Wolverhampton) showed the drawing with specimens and slides of a case of cholesterin crystals in the anterior chamber.

THE PNEUMOCOCCUS IN OPHTHALMOLOGY.

The chief feature of the proceedings on the morning of July 8th was the delivery of the Doyne Memorial Lecture by Professor K. K. K. LUNDSGAARD of Copenhagen, who took for his subject "The pneumococcus in connexion with ophthalmology." He showed a chart of the incidence of the pneumococcus on the normal conjunctiva as determined by various observers since 1909, the latest record being that obtained by himself in 1925; this was 6 per cent. The various types of the micro-organism were described and charted according to their virulence. Other charts were exhibited giving the incidence according to age and seasonal variation. A very complete survey of the part the pneumococcus plays in ophthalmology was given. Professor Lundsgaard, who at the conclusion of the lecture was presented with the Doyne Memorial Medal for the year, is to be heartily congratulated on his contribution to knowledge of the subject.

VARIOUS PAPERS.

Other papers read on the same morning were by Dr. CARSTEN EDMUND (Copenhagen), on "Colour perception in normal and night-blind persons in various illuminations"; by Lieut.-Colonel R. E. WRIGHT, who gave a summary of notes on a series of 50 cataract extractions with Green's apparatus by himself, and K. Koman Nayar; and by Dr. HOLGER EHLERS, on "Experimental researches on the corneal vessels."

CLINICAL DEMONSTRATIONS.

The afternoon of July 8th was spent at the Oxford Eye Hospital, where a series of interesting cases were shown by the Master, Mr. P. H. ADAMS, and by Messrs. HARRISON BUTLER and HARRIES-JONES. After the cases had been examined, the paper read by Lieut.-Colonel Wright in the morning was freely discussed by Lieut.-Colonel Henry Smith, C.I.E., I.M.S.(ret.), and many others.

On the morning of July 9th papers were read in the Department of Human Anatomy by Dr. J. BURDON-COOPER, on the permanent and evanescent canals of the hyaloid membrane, with a suggestion as to their function in the drainage of the eye; by Dr. MARGARET DOBSON, on insufficiency of accommodation as an important factor in the causation of incipient cataract; by Dr. HARALD GJESSING, on the results of iridencleisis operations by Holth's method, particularly as regards the method combined with meridional iridotomy; and by Mr. D. V. GIRI, on a case of high hyperphoria remedied by operation, and on a case of extreme micrography, with comments on its physiological optics.

SOCIAL EVENTS.

On the afternoon of July 7th the members of the congress and their friends were entertained to tea at Merton College, when Mr. and Mrs. de Beer acted as host and hostess; and the annual dinner of the Congress, which was well attended, was held in Keble Hall in the evening, with Professor Arthur Thomson as chief guest.

Members who attended from abroad, in addition to those already mentioned, included Dr. H. Friedenwald (Baltimore), Dr. Bernard Samuels (New York), Dr. Birger Malling (Bergen), Dr. A. Verwey (Durban), Dr. R. G. Stott and Dr. A. S. Anderson (Australia), and Dr. Pandit (India).

The total membership of the Congress is now over 400, and the attendance this year was well over the average.

British Medical Journal.

SATURDAY, JULY 23RD, 1927.

THE PRESIDENTIAL ADDRESS.

THREE of the dates which, in some sort, link the British Medical Association with Edinburgh may be taken as representative of periods in the history of medical science and practice, and as marking or giving a definite impulse to movements which have profoundly affected the outlook of the medical profession. It is possible that when next the Association meets in Edinburgh reference may, not without reason, be made, as significant of a fourth such period or movement, to the remarkable Presidential Address delivered this week by Sir Robert Philip, and reported fully in to-day's JOURNAL.

In the year 1815 Charles Hastings entered the University of Edinburgh as a student of medicine. There, no doubt, he learnt to value that "comradeship in medical science which inspired his vision of an Association for the diffusion and increase of medical knowledge, and the maintenance of the honour and respectability of the profession"; and there also, incidentally, as Sir Robert Philip reminds us, he may have "brought down a pheasant in the neighbouring woods, now Drumsheugh Gardens." At the meeting of the Association in Edinburgh in 1875, Lister, as President of the Section of Surgery, gave an address on "The effect of the antiseptic treatment upon the general salubrity of surgical hospitals," thus emphasizing the triumphant change which his work was already bringing about. In a most valuable section of his address Sir Robert Philip shows that though, on the one hand, Lister was himself a forerunner in relation to preventive medicine, yet, on the other hand, his work reflected the trend of thought and effort of his time. In 1875, at the meeting of the Association, there was for the first time a Section of Public Health, thus recognizing the new attitude which the State had adopted by the recent establishment of the Local Government Board, with its important health functions. This was itself the result of the report of a Royal Commission, whose recommendations are still worth studying, and the culmination, too long delayed, of the work of Edwin Chadwick, who, the President said, "stands related to the development of public health somewhat as Lister is to the renaissance of surgery. . . . He was one of the great master spirits, one of the first to awaken the careless public all over the world to the dangers they were creating for themselves." At the Edinburgh meeting of 1898 Sir Patrick Manson revealed the demonstration of the transmission of malaria by mosquitos, and this coincided with the establishment in the University there of a chair of public health and a lectureship on tropical diseases, and with the publication in the BRITISH MEDICAL JOURNAL of an address by Sir Robert Philip himself on the open-air treatment of pulmonary tuberculosis through sanatoriums and dispensaries by methods which, if vigorously pressed, will, he is confident from the experience of the intervening years, make tuberculosis in this country a generation hence a memory instead of a scourge.

The President entitled his address "The Strategic Front of Medicine To-day." This title admirably indicates the point of view from which his survey is taken. Having shown the paths by which the general officers commanding have led the medical profession to the position of recognizing a common interest and aim, of having regard to the ills of the community as well as of the individual, of having largely destroyed surgical dangers and eliminated whole classes of deadly disease, he finds its present alignment "relatively good." The alignment so established has had some of its salient positions fortified by the various Public Health Acts, the National Health Insurance Acts, the Education Acts, and the Acts for setting up the Ministry of Health in England and the Board of Health in Scotland. "There has been a good deal of stumbling and muddling," says the President, "but the machine, even if cumbrous and creaking, is functioning throughout the land," and "Britain possesses the amplest machinery to be found anywhere" for attaining the widening objectives.

The objectives may now be described, though Sir Robert Philip does not specifically so describe them, as prevention and perfection. Each of these objectives is being more and more recognized and insisted upon in our time, and the Presidential Address at the meeting of the Association in Edinburgh this year marks and emphasizes them, just as the former Edinburgh meetings and addresses performed in their day a function essentially similar. It is still, as always, the prime and immediate object of a medical practitioner in presence of his patient to help the individual and, if possible, cure the disease. But now, at the same time, it is becoming his almost instinctive thought in every case—"How can I learn from my experience of the distress and danger of this patient to prevent the occurrence of a like danger and distress to others?" The public health medical officer likewise has passed beyond the mere study and relief of communal unhealthy conditions to the professed aim of preventing such conditions from arising. There is no real contrast between one branch of the profession and the other; both alike have abandoned cure as their sole objective, and are now, in a varying but ever-increasing degree, envisaging prevention as their ultimate and only satisfying aim.

Yet, even so, the prevention of diseased conditions in the individual or in the community is not, in itself, the whole matter. We have previously insisted in these columns that health should be regarded, "not as the mere absence of disease, but as the complete development of body and mind—indeed, of the whole personality—to the full extent of whatever powers they possess" (JOURNAL, January 15th, 1927, p. 107). Sir Robert Philip puts it eloquently thus: "The ultimate goal is something beyond mere prevention of disease, as commonly understood. The negative attitude is too restrictive. It is scientifically insufficient and unsatisfying. The final triumph of medicine will consist not in the exclusion of disease, but in the restoration to man of perfect form and natural function: the attainment of smooth activity of body, mind, and soul. . . . With mind and eye fixed on perfection of form and function as the ultimate goal, the doctor's increasing purpose as the years roll on is the physical betterment of the race."

In the forefront of the means of reaching these objectives the President places education, not merely of the doctor, but of the public, beginning with the school child. This education should always "hark back on the biological scent. . . . Biology must be relied on to carry us further than pathology and therapeutics, as commonly understood." Through this the difficulties of using other means will be

lessened; periodic medical inspection of the individual and the consequent discovery and recognition of the early signs of disorder will follow. The policy, so long insisted upon by the British Medical Association, of a much more complete unification of health and educational administration, both centrally and locally, will tend powerfully to the same end. Unification of command, in this campaign as in others, is an elementary necessity. Further, a full and intimate co-operation, not merely between individual practitioners, but between the various sections of the profession, between hospitals and ancillary services, between nation and nation, is a condition of success.

The Presidential Address covers a wide field. It is a polished composition, expressing many wise judgements in epigrammatic sentences calling for quotation, and itself full of apt and unhackneyed quotations. It is of considerable length, but those who read it will find it, as did those who heard it, a literary delight and a remarkable survey, historical and prophetic, instructive and helpful, of the medical and public health situation in which the profession and the nation find themselves to-day.

ANNUAL MEETING NOTES.

THE ANNUAL REPRESENTATIVE MEETING.

Friday, July 15th.

THE agenda for the first day's proceedings of the Annual Representative Meeting (which, with those of Saturday, are reported fully in the SUPPLEMENT this week) included two matters of fundamental importance for the future growth of the British Medical Association. These were the Council's scheme for the development and extension of the headquarters of the Association at Tavistock Square, London, and the proposal to permit the formation in suitable cases of sectional groups on a non-territorial basis. It included also two motions which amounted, in effect, to direct votes of censure upon the Council and upon the conduct of the BRITISH MEDICAL JOURNAL respectively. The business of the day was, however, transacted with celerity, and there was an unusual absence of controversy. The preliminary proceedings opened, as was fitting, with the dispatch of a loyal message to the Patron of the Association, the King, and Her Majesty the Queen, then in residence at Holyrood. This was followed by the acclamation as President-Elect for 1928 of Sir Ewen Maclean (the first ex-Chairman of the Representative Body to receive this honour from the Association), the decision to hold the Annual Meeting in 1929 at Manchester and in 1930 at Winnipeg, and the intimation of Mr. W. E. Hempson's decision not to seek reappointment as Solicitor to the Association after this year. The reception by the representatives of the Council's proposal to confer upon Mr. Hempson the signal honour of honorary membership of the Association left no doubt as to their warm appreciation of the loyal and devoted services rendered by him during thirty years' professional and personal relationship with the Association.

The motion by Gateshead on the report of the Council's action in acquiring an interest in the Scholastic, Clerical, and Medical Association, Ltd., was, as pointed out by the Chairman of Council, a direct vote of censure upon the Council. Its withdrawal, without further discussion, after his reply had been made, marked not only vindication of the action taken in this particular case, but general appreciation of the conditions essential to the efficient functioning of the Council as the responsible executive of the Association. The Treasurer's presentation of the financial report failed to evoke more searching criticism than that conveyed by Dr. Martley in a simple question as to the financial basis of the Annual Exhibition—a subject about which, it would seem, representatives have a short memory. The reception of the report on organization, on the other hand, showed the Representative Body keenly alive to its responsibility for safeguarding at all points the stability of the Association, and determined to understand the full bearing of the facts underlying the demand for a modification of machinery of proved worth. That the questions raised were so speedily disposed of was due to the thoroughness of the preliminary exploration of the position by the Organization Committee, and the meeting seemed fully satisfied, after a very short discussion, both as to the necessity for the proposed change and the adequacy of the safeguards embodied in the scheme. The acceptance of the amendments submitted by Harrogate served merely to express more clearly the original intentions of the Council. The remainder of the organization report was the occasion of cordial tribute to the outstanding success of those carrying on propaganda amongst the newly qualified, and in particular of the record established by Glasgow in May of this year, when 100 per cent. of the new graduates applied for membership of the Association. The plea from Lanarkshire for the concession of out-of-pocket expenses for those engaged in the central work of the Association, whether on the Council or committees, was remitted to the Council for the periodical reconsideration which the question has always demanded. It lost nothing of its interest and force in Dr. Miller's presentation.

The main business of the afternoon session was consideration of the building scheme, its main feature being what was aptly characterized by the Chairman as "the extraordinary glamour of a brilliant exposition" by the Chairman of Council. The unhesitating and enthusiastic reception of a scheme of such magnitude in principle and detail was a tribute, in Dr. Christine Murrell's words, to the educative power of Sir Robert Bolam. If this was in fact the "last of a series of lectures," it was also, contrary to the general experience in such matters, indisputably the best. Difficulties and questions were dealt with as frankly and effectively as the main theme, and where the same unmeasured approval has been expressed alike by the "forefathers" of the Association and its "youngest member," the Council may surely go forward with full confidence in the ultimate issue of the undertaking. The latter part of the afternoon's debate brought forth what might have proved a serious element of controversy in the motion from Brighton on the conduct of the BRITISH MEDICAL JOURNAL in regard to a particular matter. The Representative Body as a whole, however, seemed hardly to require the explanation it elicited from the platform of the elements of responsible management. The motion was received as what in fact it was—an expression of dissatisfaction with conditions which, while inevitable from the nature of the case, must none the less prove on occasion a cause of offence to the individual, and in a special degree to one who holds strong views. On the ethical report the solution put forward for the long-standing difficulty as to the limits of the legitimate advertisement to the profession of therapeutic institutions raised the first general discussion of the session, and the contribution of Dr. Radcliffe and Dr. D'Ewart to the definition of the class of notice to be excluded was accepted as an improvement upon the formula submitted. The comment upon Indian experience supplied in Dr. Kapadia's lucid and vigorous speech was none the less appreciated because it was felt to provide insufficient grounds for a drastic modification of the practice determined over a long period by the different conditions of this country. The evidence of activity in India in the defence of the standards of professional conduct was received with warm approval.

Saturday, July 16th.

Owing to the regretted temporary illness of the Chairman of the Representative Body, the chair was taken on Saturday morning by the Deputy Chairman, Dr. Hawthorne; but, the first item on the agenda being the science report, Dr. Wallace Henry was appointed chairman for the period of that discussion. Of the four proposals submitted by Dr. Hawthorne for regulating, on sound lines of public policy, the development of pathological practice, the first, designed to check the commercialization of pathological work involved in the offer of examinations and reports on individual cases by trading firms, hardly required explanation and commanded general assent. The second, fixing responsibility for all reports issued upon the medical practitioner in charge of the laboratory, was equally acceptable; but the third, which sought to define and limit the field of action of the public health authorities in the provision of laboratory services, and the fourth, designed to secure facilities for the extension of private pathological practice in connexion with the general pathological services offered by hospitals and medical schools, aroused considerable opposition, expressed in the course of a general debate of much interest. The object of the proposal concerning the activities of the public health laboratory was to restrict the development of what is, in effect, subsidized competition with the independent pathologist, while at the same time safeguarding the interests of patients to whom some local authorities are rendering a useful service not otherwise available. There was perhaps some fear that the discussion might turn upon one of several relatively narrow issues—the exploitation of the pathologist, the immediate convenience of the general practitioner, or the economic advantages of concentrating the greatest possible amount of pathological work in one laboratory. If this were so, the danger was averted by Dr. Dyke's clear and forcible statement of the position. The real issue at stake is the free development of pathology as a branch of medical science, and one of the most immediate dangers to be met is exclusion of the pathologist from contact with the patient, and the stereotyping of pathological practice on the lines of the public health laboratory, excellent as such institutions may be within their own limited sphere. The general discussion showed a variety of individual experience quite sufficient to emphasize once again both the danger of arguing from the particular to the general, and the urgent need for laying down some guiding principles for any new movement before sound progress is impeded by haphazard development. What one representative, on the basis of his own experience, considered impossible, the next showed to be practicable; what another thought undesirable was shown to be at least temporarily advantageous in some circumstances. Rejection of the amendment proposed by Brighton, and adoption of the amendment by Mr. Souttar and Mr. McAdam Eccles, left the whole matter in such a position that its reference back to the Council was clearly the best expedient. In accepting it as such Dr. Hawthorne took occasion, however, to indicate the danger of developing a habit of referring points of difficulty back to the Council. The Gateshead amendment to exclude from the JOURNAL advertisements of certain pathological institutions at first sight appeared to be a logical sequel to the policy already endorsed. Losing nothing in its terse and vigorous presentation by Dr. Forbes, and supported by the considered opinion of two Divisions, it was admitted as ideally equitable by the Chairman of the Science Committee and treated sympathetically by the Chairman of Council. It was rejected on grounds of immediate convenience, with something more than the measure of recognition usually accorded to truths urged out of due time. Another matter of the first importance was submitted to the meeting in the Science Committee's proposals for collective investigation. The reception of this scheme was cordial enough to warrant the hope that its introduction will mark a substantial advance in a field where the Association has already done good service. The few comments served to show the importance of the work, its inherent difficulty, and the care with which the scheme had been drafted by the special subcommittee.

THE LUNACY LAW MEMORANDUM.

A memorandum from the Lunacy Law and Mental Disorder Committee came before the Representative Meeting in unusual circumstances. It will be remembered that a special committee was appointed three years ago to draw up a memorandum of evidence to be submitted on behalf of the British Medical Association to the Royal Commission on Lunacy Law and Mental Disorder. This committee also gave oral evidence before the Commission. On the publication of the Royal Commission's report in 1926 a committee with the same personnel was appointed to examine its recommendations in relation to the evidence submitted by the Association, and to this committee the Council also referred a resolution from the Representative Meeting at Bath, requesting the Council to "take all necessary steps as soon as possible to deal with the situation that has arisen as a result of the findings of the jury in the Harnett *v.* Fisher case with the view of protecting the interests of the medical profession." The detailed examination of the Royal Commission's report was no light task, and this fact, combined with the long delay in the termination of the Harnett case, and the necessity in this connexion for keeping a careful watch upon the development of two other legal actions—namely, those of Hume-Spry *v.* Smith and Another, and de Freville *v.* Dill and Another—made it impossible for the committee to present its report to the Council at a date sufficiently early to secure for it adequate consideration and inclusion in this year's Supplementary Report. In these circumstances it seemed desirable to find some means both of informing the Representative Body of the progress of the work referred to the committee, and of eliciting from it some expression of opinion for the guidance of the Council in the event of action being called for before next year's Representative Meeting. Accordingly the Chairman of the Lunacy Law Committee undertook to submit to the representatives a memorandum embodying the conclusion already formulated by it. This memorandum was circulated to the representatives with the agenda of the Annual Representative Meeting, and presented to the Representative Body by Dr. Langdon-Down. The memorandum consisted of four sections, of which the first indicated the very great measure of agreement between the principles embodied in the report of the Royal Commission and those advocated by the Association in its memorandum of evidence; the second made certain proposals with regard to the protection of the medical practitioner in the performance of the duties imposed upon him by the Lunacy Acts; the third indicated the points at which, in the opinion of the committee, the practical proposals of the Royal Commission are not calculated to promote the desired extension of facilities for the treatment of patients suffering from mental disorders; and the fourth indicated the general position in respect of the legal actions mentioned above, and the necessity for further examination of the issues they have raised.

The main difference between the recommendations put forward in the memorandum and those embodied in the evidence tendered to the Royal Commission lay in the method suggested for securing the desired protection for the medical practitioner. The original proposal of the Association, as embodied in a resolution of the Representative Body in 1924, was as follows:

> That the provision of a certificate under the Lunacy Acts by a qualified medical practitioner should be an act having the legal status of testimony given by a witness in a court of law,

and should not render the practitioner liable either to any civil action or to any criminal charge, except in so far as the certificate may be shown to contain statements of essential importance which are proved to be inaccurate and to have been made with a wilful and deliberate intention to deceive.

The proposal was rejected by the Royal Commission, after full and sympathetic discussion with the Association's witnesses on more than one occasion; and the committee, for reasons set out in its memorandum and explained by Dr. Langdon-Down in placing it before the meeting, recommended the adoption, as an adequate remedy for the existing state of affairs, of certain alternative methods. In moving approval of the memorandum and its reference to the Council, the Chairman of the Committee pointed out that he desired rather a general endorsement of the lines of the memorandum than a definitive approval of its actual terms. Several amendments stood on the agenda, and in the course of the prolonged discussion, of which a detailed report will appear in the next issue of the SUPPLEMENT, it was made clear that the Representative Body was not prepared to commit itself even to this qualified approval of proposals which it had had so little opportunity of weighing with due deliberation. Dr. Langdon-Down therefore accepted the following amendment proposed by Dr. Hawthorne:

That the representatives thank the Lunacy Law and Mental Disorder Committee for the memorandum on the report of the Royal Commission on Lunacy Law and Mental Disorder, refer it to the Council, and request the Council to reappoint the committee with instructions to take whatever steps are possible to secure what the report of the Royal Commission declares to be "fair," namely, that the medical profession should not be asked "to perform their essential part under the menace of litigation which even if unsuccessful may spell financial or professional ruin."

LUNCHEON TO OVERSEA REPRESENTATIVES.

On the opening day of the Annual Representative Meeting the officers of the Association, the oversea representatives on the Council, and the Chairmen of the Organization and Dominions Committees entertained at luncheon in the University Union the representatives of oversea Branches and Divisions who are taking part in the proceedings at Edinburgh. Dr. H. B. Brackenbury, Chairman of the Representative Body, presided. In proposing the health of the guests he said that the custom of holding this luncheon party was only a few years old, and each year it became more important and friendly and enthusiastic. He and his colleagues were delighted to have so many oversea representatives present, and to take the opportunity of reciprocating the welcome always given by members in distant countries to visitors from home. It was the wish of the Representative Body that the oversea members should take a real live part in its proceedings. Sir David Galloway (Singapore), in acknowledging the toast, said how much he had been impressed by the thoroughness and care given by the Representative Body to every item of its agenda. The power and prestige of the British Medical Association were of special value to the medical profession in countries with small Governments, and the backing of the parent Association had always been of great assistance in Malaya. Mr. Lindsay Sandes (Cape Western, South Africa), speaking of what the Association had done for the profession in South Africa, said that Dr. Cox during his recent tour brought with him just that atmosphere of activity and *bonhomie* which was wanted. Thanks largely to his efforts there was now only one organized medical body. To achieve anything in dealings with Governments the profession must speak with one voice. Dr. J. L. Rubidge (Cape Midland, South Africa) added his praise of Dr. Cox's tact in bringing people together over delicate and difficult matters. Dr. S. P. Kapadia (Bombay) spoke of the need for uniting the different medical bodies in India, so that the voice of the profession might be better expressed and better heard. He hoped the British Medical Association would undertake this task. Dr. Spencer Wicks (Griqualand West, South Africa) testified to the invaluable pioneer work for the profession in South Africa accomplished by Dr. J. A. Macdonald during his tour in 1920. Dr. Q. B. de Freitas (British Guiana) briefly expressed his sense of the advantages derived by himself and his fellow members through the help given from headquarters, and the short informal speeches ended with a dozen words by Dr. Macdonald on the need for personal intercourse between the centre and overseas. The joint hosts with Dr. Brackenbury were Sir Robert Bolam (Chairman of Council), Mr. Bishop Harman (Treasurer), Dr. Morton Mackenzie (Chairman of the Organization Committee), and Sir Jenner Verrall (Chairman of the Dominions Committee). The other oversea guests present were Dr. E. Howard Bannister (Barbados), Dr. T. C. Boyd (Western Australia), Dr. W. Dunlop, O.B.E. (Mesopotamia), Dr. E. A. Falkner (Queensland), Dr. A. Gow (Pretoria), Mr. Max Greenberg (Witwatersrand), Mr. G. M. Huggins (Mashonaland), Major M. G. Naidu (Hyderabad), Dr. L. D. Parsons (Ceylon), Dr. W. H. Peacock (Sierra Leone), Dr. S. A. Smith (New South Wales), Dr. S. S. Strahan (Hong Kong), and Dr. B. T. Zwar (Victoria). The company also included the President of the Association, Mr. R. G. Hogarth; the President-Elect, Sir Robert Philip; Dr. C. O. Hawthorne (Deputy Chairman of the Representative Body), Dr. Fergus Hewat (local General Secretary), Lieut.-Colonel Ashton Street, I.M.S. (ret.), Dr. J. Barcroft Anderson, and Dr. G. Clark Trotter; together with the senior officials of the Association, and the Solicitor, Mr. W. E. Hempson.

THE RELIGIOUS SERVICE.

The official religious service, which had special reference to the Lister commemoration, was held in St. Giles's Cathedral on Tuesday afternoon, when the preacher was the Very Rev. W. P. Paterson, D.D., LL.D., Dean of the Faculty of Divinity of Edinburgh University, Chaplain-in-Ordinary to the King, and the service was conducted by the Very Rev. Charles L. Warr, M.A., Dean of the Order of the Thistle, and the Very Rev. Adam Philip, D.D., of Lornforgan. The lessons were read by the Right Hon. Alexander Stevenson, Lord Provost of Edinburgh, and Sir Robert W. Philip, M.D., LL.D., President of the Association. Members assembled and robed in the Signet Hall, by courtesy of the Society of Writers to H.M. Signet, and then proceeded to the Cathedral, headed by the President, the Chairmen of Council and of the Representative Body, the Treasurer, and other officers. Members and officials of the Corporation of Edinburgh were present, marching in a procession, from which old-time pageantry was not absent, from the city chambers. The Presidents, members of Council, and Fellows of the Royal Colleges of Physicians and Surgeons of Edinburgh also attended.

Dr. Paterson said, in the course of his sermon, that one hundred years after his birth they were met to lay a wreath on the tomb of Lister, whose title to fame was that of one of the chief benefactors of suffering humanity. Edinburgh, the city and University, shared in the glory, for it was there that, under a master of his craft, he served his apprenticeship as surgeon and lecturer, there he founded his home, and there, as professor for eight years, he clarified his theory and matured his method. When in 1877 he returned to London it was in the spirit of the missionary who went forth to publish his good news *in partibus infidelium*. Lister, the preacher continued, had a personality which matched his genius. At a time when religious bewilderment was widespread and negation was a fashion, he clung to his Christian creed. He exhibited that blend of gentleness and courage which had marked the finest type of Scottish character, and his life could be described in terms of the story of the Good Samaritan. Dr. Paterson passed on to consider whether new discoveries,

such as Lister's, in regard to the treatment of bodily disease had any analogy in relation to the higher life of man. He pointed out several such analogies. The well-being of the body was health, the well-being of the soul was goodness, virtue, and character; and both alike were assailed by mischievous forces, insidious and unseen, the "terror by night," which, in the physical realm, Lister did so much to combat. The soul equally with the body lay open to the attack of hostile elements which threatened it with damage and even with ruin, and the question was whether there could be discovered an availing "spiritual asepsis," a shield against moral infection, whether the soul could be safeguarded against the evil influences to which it was being constantly exposed. The truth was that just as the safety of the body lay in the possession of vitality and vigour which gave or increased the powers of resistance, so, on the spiritual side, the great requirement was that the individual should have life within him, and have it more abundantly, or, in the language of St. Paul, that he should be "filled with the spirit." In other words, only the mind and character inspired by pure affections and noble loyalties would naturally and easily abhor that which was evil and cleave to that which was good. This lesson was impressively illustrated in the life of Lister himself—the power of a noble character, with its settled dignity and the promise that it carried of victory over the world. The master principles of his character were love of truth, love of suffering men, and a passion for the service of humanity, and to these should be added his deep faith in God and a strong sense of responsibility to his Maker for the use of the talents committed to his trust. The preacher quoted from the Listerian Oration by Professor Stewart to the effect that Lister's pupils and fellow workers said with emphasis that he was as good as he was great. The service concluded with the anthem,

> "God be in my head
> And in my understanding."

RECONSTITUTION OF INTERNATIONAL OPHTHALMOLOGICAL CONGRESSES.

THE Convention of English-speaking Ophthalmologists, at a meeting held in London in 1925, asked its President, Mr. Treacher Collins, to nominate a small committee to bring about a renewal of the periodical International Ophthalmological Congresses which, previous to the war, were held every fourth or fifth year. Mr. Collins nominated Dr. Edward Jackson of Denver, Dr. George de Schweinitz of Philadelphia, Sir John Parsons and Mr. Leslie Paton of London to be members of this committee, of which he himself acted as convener. The work of this committee during the last two years resulted in the calling of a conference at Scheveningen (July 12th to 15th), which was attended by forty-eight delegates, representing twenty-five different nationalities. Of these delegates one came from Chili (Dr. Thierry), two from the Argentine (Dr. Arganarez and Dr. Demaria), two from Japan (Professor Hata and Lieut.-Commander Tagawa), two from the United States (Dr. de Schweinitz and Dr. Parker), and two from Egypt (Dr. Meyerhoff and Dr. Riad). All the principal European nations, except Russia, Turkey, and Greece, were represented. The preparations have involved a considerable amount of work for the Anglo-American committee during the last two years, but the result has fully compensated them. They, however, recognize that much of the great success of the conference was due to the hospitality and forethought of the Dutch hosts, Professor van der Hoeve of Leyden, Professor Rochat of Gröningen (President of the Netherlands Ophthalmological Society), and Dr. Marx of Leyden. On the afternoon of July 12th, after Professor Rochat had welcomed the delegates in English, French, German, and Italian, Mr. Collins explained the circumstances which had led to the summoning of the conference, and gave a short history of previous International Congresses. On his motion Professor van der Hoeve took the chair, and Mr. Leslie Paton of London, Dr. Marx of Leyden, and Dr. Pflüger of Berne were appointed secretaries of the conference. The principal motion, "That the International Congress of Ophthalmology be reconstituted," was carried by acclamation, and four committees were appointed—(*a*) to consider rules and by-laws, (*b*) to consider the place and date of the first meeting and the subjects for discussion, (*c*) to consider the question of finance, and (*d*) the questions of international ophthalmological importance which should be remitted to the council for discussion. In the evening the Anglo-American Convening Committee entertained the delegates to dinner. The committees met on the morning of July 13th, and so smoothly did the work go that all the reports were ready before 11 o'clock. In the evening Professor and Mrs. van den Bergh entertained the delegates to dinner and a garden party in their beautiful garden at Wassenaar near The Hague. On July 14th the committees presented their reports, and it was announced that invitations had been received from Denmark, Egypt, and Holland for the first congress and from Madrid for the second congress. It was unanimously decided that the first congress should be held at Amsterdam in September, 1929. The new rules and by-laws were unanimously adopted; the subscription was fixed at £2 sterling, or an equivalent sum, for members, and £1 for associates. Apart from the expenses of the congress itself, a fund will be required to meet the expenses of the international council, which is to hold office in the period intervening between the congresses. To meet expenses incurred in preparation for this conference and other council expenditure, it was resolved to ask for voluntary subscriptions of not more than £5 or less than £2 from ophthalmological or other medical societies or from individuals. Any society subscribing will be entitled to receive a copy of the transactions of the congress. The management and finances of the congress itself will be controlled by a national committee, elected by the ophthalmologists of the country in which the congress is to be held. The council was asked to select the subjects for discussion, both by the congress and by special committees to be appointed by the council. An international council was appointed, to hold office until the congress of 1929. It consisted of Professor van der Hoeve (Netherlands), chairman; Professor Lundsgaard (Denmark), vice-chairman; Mr. Leslie Paton (Great Britain), treasurer; Dr. Marx (Netherlands), secretary; Geheimrath Professor Axenfeld (Germany); Dr. Byers (Canada); Professor Coppez (Belgium); Professor Marquez (Spain); Professor Meller (Austria); Dr. Morax (France); Professor Ovio (Italy); and Dr. de Schweinitz (United States). Mr. E. Treacher Collins was elected honorary president of the international council by acclamation, and as a tribute to all the work he had done towards ensuring the success of the conference and the future of international ophthalmology. After the congress the delegates were taken by cars to Nordwyk-on-Sea, where they were entertained to lunch by Professor van der Hoeve; afterwards they visited the palatial new ophthalmic clinic at Leyden, and looked with envy on the spacious rooms and ample accommodation provided there for ophthalmological work. It would be wrong to conclude any notice of this conference without remarking on the friendliness and unanimity with which every member worked towards securing the common aim. Those who had worked together to bring about the meeting were not altogether free from anxiety as to how matters would turn out, but in the very first moments these doubts were removed, and subsequent meetings only increased the feelings of good fellowship. Undoubtedly the extremely generous hospitality which was shown on all hands had

much to do with this, and none who took part in the proceedings will readily forget the visit to the lakes or the evening at Wassenaar and the delights of Mr. and Mrs. van den Bergh's party, or the luncheon party given after the meeting by Professor van der Hoeve, with the surprise speech delivered by Professor Ask of Sweden in fluent and classical Latin, so that all the delegates might understand it without the necessity of translation! The thanks of the ophthalmological world are due to those who worked so hard to bring about this meeting, and to render the prospect of renewed ophthalmological congresses so rosy. Certainly, no one who visited Holland on this occasion will want to miss the congress at Amsterdam in September, 1929.

COLONIAL MEDICAL RESEARCH COMMITTEE.

A PROPOSAL for the establishment of a joint committee of the Colonial Office and the Medical Research Council was endorsed by the Colonial Office Conference held this year, and the Secretary of State for the Colonies, in consultation with the Medical Research Council, has now appointed the Colonial Medical Research Committee "to advise the Secretary of State and the Medical Research Council upon the initiation and promotion of medical research in the interests of the Colonial Empire; upon the recruitment and conditions of service of the necessary personnel; and upon the management and allocation of any funds available for these purposes." The committee will also investigate proposals for the creation of a Colonial Medical Research Service, and for the payment, from a pool, of grants to medical institutions which are considered to deserve the support of Colonial Governments. The chairman of the committee is Mr. W. Ormesby-Gore, M.P., Parliamentary Under Secretary, Colonial Office, and the deputy chairman Sir George Maxwell, K.B.E., C.M.G. The secretary of the Medical Research Council (Sir Walter Fletcher, K.B.E., M.D., F.R.S.) and Dr. A. T. Stanton (Chief Medical Adviser to the Secretary of State for the Colonies) are *ex officio* members. The other members are: Dr. J. W. W. Stephens, professor of tropical medicine, Liverpool; Sir Leonard Rogers, C.I.E., M.D., F.R.S. (late I.M.S.); Dr. Andrew Balfour, C.B., director of the London School of Hygiene and Tropical Medicine; Dr. Charles Todd, who has been director of public health of the Public Health Laboratory, Cairo; Dr. P. H. Manson-Bahr, D.S.O.; and Dr. C. M. Wenyon, C.M.G., F.R.S., director of the Wellcome Bureau for Scientific Research.

SPA TREATMENT FOR INSURED PERSONS.

IN the SUPPLEMENT to our issue of March 12th (p. 85) will be found a report of a conference, called by the British Medical Association, on spa treatment for insured persons. The subject has been under consideration at the annual congress of the Royal Sanitary Institute at Hastings, of which some details are given at page 144. A paper was read by Mr. John Hatton, director of baths at Bath. In advocating spa treatment as one method of helping to reduce the expenditure of £2,000,000 a year by approved societies for rheumatic persons, Mr. Hatton claimed that 87 per cent. of patients were discharged cured or relieved from the hospitals at three of the principal British spas. These patients, however, represented very few of the 372,600 insured persons who suffered each year from rheumatic diseases. Mr. Hatton outlined the scheme of the British Spas Federation for the extension of facilities for treatment. The doctor would send a history and report of his patient to the medical board of the nearest suitable spa. If the patient seemed likely to be benefited the doctor and the patient would be notified, and the patient received as soon as accommodation became available. Under present conditions some 30,000 patients could be treated annually at British spas, the majority as out-patients at the spa hospitals already existing. Facilities for *x*-ray examinations, and biochemical, bacteriological, and other investigations would be provided, thus increasing the opportunities for research and improvement in treatment. The patients would be seen at a consultation centre; they would be treated in the bathing establishments; and they would be accommodated at the less expensive boarding-houses at a fixed rate, with a simple scheme of dietary laid down by the medical board. Later on it might be possible to establish hostels for insured persons. Such patients would be required to observe certain rules of general behaviour, to return to their lodgings at stated hours, and to refrain from obtaining refreshment outside. The discipline of patients and the standard of lodgings would be maintained by a supervisory committee of approved society representatives. The utilization of existing boarding-houses would permit of patients being accompanied by members of their family. The whole of each local organization would be controlled by a National Health Insurance Spa Council, with representatives of the corporation or other spa authority, of the medical board, the spa hospital, the supervisory committee of the approved societies, and of the local Insurance Committee. The British Spas Federation would maintain a connexion between spa councils, approved societies, and the Ministry of Health. In Mr. Hatton's opinion the scheme outlined would avoid the setting up of fresh administrative machinery and the outlay of capital; it required no new buildings, asked for no charity, and did not disturb the rich who were enjoying the benefits and pleasures of the spas.

INDUSTRIAL FATIGUE RESEARCH.

THE Industrial Fatigue Research Board has just issued its seventh annual report—to December 31st, 1926. The previous report contained an analysis of all the published work of the Board, so that it is thought unnecessary to enter again into the full significance of the work and its results. But the Board is convinced that interest is expanding, even if general realization of the possibilities of research is slow. Industrial difficulties have hindered development, and caused industrialists to concentrate their attention on technical and mechanical developments. Nevertheless in many cases where an experimental change has indicated a favourable result, the new conditions have been retained in the particular factory. The Board is of opinion that the time has arrived when a change of this kind should not be limited to one factory, but should be tried on an extensive scale throughout the industry. As examples of changes suitable for large scale experiment there is mention in the report of the breaking up of the spell of work by rest pauses, the increase in air movements in work involving high temperatures, and the use of standardized methods of training. In these and other instances the changes suggested by the Board's experimenters have proved beneficial both to the worker and his work. In order to promote the adoption of these changes the Board urges again a suggestion, made in its fourth report, that small committees of employers and workmen should be formed in the more important industries, for discussing and submitting for investigation problems affecting the human factor in the industry, for considering proposals made by the Board or by the National Institute of Industrial Psychology, and for applying experimentally such methods as are considered appropriate to the industry. For these reasons the Board invites once more closer relations with industries. The subjects investigated last year are grouped under three headings: (*a*) investigations of particular problems of wide industrial importance, (*b*) studies of specific problems

submitted by Government departments and by industrial associations, (c) experimental researches undertaken in university and other laboratories. Under the first heading come such matters as hours of labour, accident causation (in which it is suggested that some persons have a special personal susceptibility), design of machinery, ventilation, vocational guidance, and so on. Under the second heading studies were made in sickness in cotton weaving and printing, in weight carrying by women, atmospheric condition in mines, telegraphists' cramp, vision and lighting, and vocational selection. Laboratory researches related to muscular work, to muscular skill, to the influence of menstruation on working capacity, and to the factors involved in the psycho-galvanic reflex. The conclusions on many of these subjects have already been dealt with in our columns when the reports were issued.

THE KING'S PRIZEMAN.

THE King's Prize at Bisley was won on July 16th by Captain Cecil Heygate Vernon, late R.A.M.C. Last year, it will be remembered, Dr. F. H. Kelly tied for the King's prize, but in shooting off was beaten by one point by the winner, Sergeant A. G. Fulton. So far as we are aware, this is the first occasion on which the King's Prize has been won by a member of the medical profession. Captain C. H. Vernon is a Hampshire man by birth, 45 years of age. He was educated at Oundle School, at Cambridge, and at St. Thomas's Hospital. In 1918 he graduated M.A., M.B., and B.Ch. at Cambridge, and took the M.R.C.S. and L.R.C.P.London. He also took the F.R.C.S.Ed. in 1920. He held the appointments of senior casualty officer and resident anaesthetist at St. Thomas's, and is now assistant surgeon and assistant obstetrician to the Royal Victoria Hospital, Bournemouth. He is a member of the British Medical Association. During the earlier part of the war Captain Vernon served as a combatant officer in India and Mesopotamia, in the 2/5 Hampshire Regiment. Subsequently, after qualifying, he transferred to the R.A.F. Medical Service, and later to the R.A.M.C. While at Oundle he was in the school shooting eight, and shot for his school in the Ashburton Shield competition in 1910 and 1911. In 1913 and 1914 he shot in the Cambridge eight for the Humphrey Cup, which was won by Oxford in both years. But in 1913 he was one of the team which won the Chancellor's Plate for Cambridge. After the war he became a member of the Inns of Court and of the Christchurch, Hants, Rifle Clubs. He was among the hundred competitors for the King's Prize in 1923, 1924, and 1925, but failed to get a place last year. This year he has won one other first prize, the "Extras" Aggregate, and in the Mackinnon competition on July 14th he made the highest score for England. On July 16th, when the final shoot at 1,000 yards began, Captain Vernon, with 218 points, was four behind Sergeant A. G. Fulton, who has twice won the King's Prize. With his tenth shot Vernon overtook Fulton, with his eleventh passed him, and maintained his lead to the end, with a total score of 292 points. Lieutenant T. D. Burke of Canada was second with 291, Lieutenant Congreve-Pridgon, another Hampshire man, late 2/7 Hants Regiment, was third with 290, and Sergeant Fulton fourth with 289. Captain Vernon's score was six points higher than last year's winning score, but, as new conditions were introduced last year, an exact comparison with previous years can hardly be made. The prize consists of the gold medal, gold badge, and £250. After his victory Captain Vernon was carried round the camp in the prizeman's chair by men of both universities, with an escort of mounted Lancers, followed by the Dorsetshire Regiment, to the R.N.A. offices. There, as a total abstainer, he declined the glass of champagne which awaits every prizeman.

THE ROYAL SANITARY INSTITUTE CONGRESS AT HASTINGS.

THE twenty-eighth annual congress of the Royal Sanitary Institute was held at Hastings from July 11th to the 16th. More than 800 delegates were present, representing Government departments, municipal authorities, the Overseas Dominions, and foreign countries. A health exhibition organized in connexion with it included devices for disinfecting the water in swimming baths and for economizing labour; apparatus for heliotherapy in private practice and in large clinics was demonstrated. At the congress dinner, on July 14th, Dr. S. Kojima advocated closer co-operation between Great Britain and Japan in sanitary administration and research.

Presidential Address.

The presidential address was given by Sir WILLIAM JOYNSON-HICKS, who devoted considerable attention to factory legislation. He said that in the great changes effected during the last half-century in the sphere of public health the Royal Sanitary Institute had played a very important part. The worst sanitary evils had now been abolished, but slum conditions still persisted in some places, and special difficulties in developing urban civilization, such as the smoke problem, called for continued efforts. The great task of the Sanitary Institute was the diffusion of knowledge, the education of public opinion, and the training of officers not merely to detect nuisances, but also to give skilled advice how faults might be avoided or remedied. Passing to the Factory Acts, he said that these concerned about 6,000,000 people, and the circumstances of their employment. Many workers left home in the early morning and spent the hours until evening in the factory or its precincts; the conditions there prevailing of light, air, heat, the taking of meals, and sanitary arrangements had an important influence on health and efficiency. In the past factories had been designed from the narrow standpoint of utility; such buildings had few conveniences and were ill lighted and poorly ventilated. It was now recognized that the provision of adequate space, light, and amenities was an economy; the better the conditions were made, the larger the output would be. It was twenty-six years since the last general factory law had been passed, and in spite of amending bills and codes of regulations, factory legislation had not kept pace with advances in scientific knowledge and the general development of industry. The Government proposed next session to introduce a new Factory Bill with the general object of raising the standard in the more backward factories to the level of the more progressive ones. In many old buildings the conditions were poor, and in some food factories the floors were coated with deposits of sugar and flour, which it was very difficult to remove. The new bill would aim at protecting the public by strengthening the provisions for cleanliness, as in the case of food factories; it should also improve still further the health of the workers. An attempt would be made to define a standard of illumination, since deficient lighting depressed the worker's health and spirits, and reduced his industrial efficiency. The question of ventilation would be considered, not only with regard to definitely noxious vapours, but in its widest sense, with recognition of the importance of fresh, frequently changed, and dust-free air. The personal hygiene of the workers had greatly improved during recent years, particularly in the case of women and girls. This development should be encouraged by making suitable provision in factories for cloakrooms, washing facilities, and the use of overalls. Medical supervision of the workers was an important question in all cases, and not only in trades recognized as specifically dangerous. Attention had been devoted recently to the danger of infection after accidents which had been often of a comparatively trivial nature; more than 15,000 cases of sepsis were reported from factories annually. First-aid boxes were compulsory, but much still remained to be done in educating workers as regards the need of antiseptic precautions. Dental clinics were often provided and had assisted the spread of education in hygiene of the teeth. Medical supervision was especially necessary in the case of certain factories in

which sickness was above the average, or a generally low standard of health prevailed, though there was nothing substantially injurious in the manufacturing processes concerned. In the new bill it was proposed to give the Home Secretary power to require such medical supervision after consultation with the Ministry of Health.

Chronic Rheumatism in Relation to Industry.

Sir WILLIAM WILLCOX delivered the congress lecture on the effect of chronic rheumatism in industry. He said that recent research by the Ministry of Health had decisively demonstrated that the most disabling disease as regards loss of work and impairment of industrial efficiency was rheumatism. In the chronic form the involvement of the joints and fibrous tissues, and the resistance of the condition to treatment, were very striking features of the disease. In addition to the local manifestations, the general weakness, anaemia, and gastro-intestinal disorders required careful attention. The speaker referred at length to the report of the Ministry of Health in 1924 on the incidence of rheumatic disease among industrial workers, and said that, 'taking as a standard the analysis made of the sickness rate among 91,000 insured persons in 1922, the total amount paid in sick benefit in that year on account of rheumatic diseases would exceed £1,800,000, while over 3,000,000 weeks of work were lost annually owing to this cause; chronic rheumatic joint diseases cost the approved societies nearly half this sum. Sir William defined four etiological factors—namely, toxaemia, constitutional defects, skin conditions, and external causes, such as climate, diet, and humidity. Passing to prophylaxis, he emphasized the importance of treating effectively in early life unhealthy conditions of the alimentary and respiratory tracts, including dental sepsis, and of securing healthy conditions of working and housing. He advocated closer co-operation of all the existing agencies for treatment and the establishment of clinics for dealing with rheumatic diseases.

Sanitary Science and Preventive Medicine.

Sir JOHN ROBERTSON, in his presidential address to the Section of Sanitary Science and Preventive Medicine, dealt with the care of the human body, and said that while health authorities had concerned themselves mainly with communal measures, the individual ought to look after himself more carefully than was at present the case. Care of health should be taught more fully in elementary schools and be a compulsory subject in matriculation examinations, so as to stimulate a more intense demand for improved conditions in factories, offices, and shops. Elementary physiology should be made a living and interesting branch of education with a view to encouraging practical personal hygiene. This Section held two discussions: in the first Dr. F. M. R. WALSHE described the epidemiology of poliomyelitis, and called attention to the possibility of milk being concerned in the transmission of this disease as well as healthy human carriers and infected patients. Dr. A. S. MACNALTY dealt generally with notifiable diseases of the central nervous system, and Dr. J. A. H. BRINCKER considered these infections with special relation to school children. The control of small-pox was the subject of the second discussion. It was opened by Dr. F. E. WYNNE, who described the outbreaks in Sheffield since 1922, and advocated more stringent isolation of cases with supervision of contacts. A keen debate followed, in which Drs. R. P. GARROW, R. W. JAMESON, C. KILLICK MILLARD, J. T. BIGGS, C. S. THOMSON, and T. S. MCINTOSH took part.

Maternity and Child Welfare.

The first day's meeting of the Section of Maternity and Child Welfare was devoted to the care of children. Dr. J. A. HADFIELD read a paper on the principles of mental health in the child, emphasizing the importance of allowing more freedom for development and the formation of ideals. Mr. P. B. TUSTIN, late manager of the Bureau of Child Welfare, Winnipeg, gave an account of the development of child welfare work in that city. Dr. ERIC PRITCHARD enumerated the recent improvements in methods of artificial feeding, and Sir FRANK COLYER discussed the prevention of dental caries in children. On the second day Sir BERNARD SPILSBURY described the pathology of puerperal fever, and Dr. J. BRIGHT BANISTER read a paper on the prevention of this disease by co-operation between the various maternity agencies, including the medical practitioner, the local authority, the midwife, and the public. Dr. A. REMINGTON HOBBS criticized the official definition of puerperal sepsis, and considered the prevailing high mortality and morbidity, while Dr. C. S. THOMSON reviewed the administrative problems concerned.

Hygiene.

The Hygiene of Food Section discussed public health considerations associated with the preparation, inspection, and consumption of canned meat, fish, fruit, and vegetables, and Dr. W. M. WILLOUGHBY described the practical examination of these foods. A meeting of the Section of Hygiene in Industry was devoted to factory legislation, and Dr. FRANK SHUFFLEBOTHAM read a paper on industry and disease. The Section of Veterinary Hygiene reviewed the question of pure milk as affected by recent legislation, and the opinion was expressed that, as at present administered, the regulations were insufficient to secure the supply of milk free from tubercle bacilli, or to abolish tuberculous disease in cattle.

Conferences.

At a conference of representatives of sanitary authorities papers were read on the psychology of health publicity and the improvement of the food supply. Dr. S. T. BEGGS dealt with health education, and Professor H. R. KENWOOD advocated the use of the public abattoir. At a conference of representatives of the authorities of health resorts, Dr. R. FORTESCUE FOX discussed the spas of Great Britain and their value from a medical point of view. Dr. W. G. WILLOUGHBY (Eastbourne) considered seaside health and holiday resorts from the health standpoint, and papers on spa treatment for the insured were read by Dr. M. B. RAY, Mr. W. A. APPLETON, secretary of the General Federation of Trade Unions, and Mr. JOHN HAITON, honorary secretary of the British Spas Federation; to the last of these reference is made at page 143. Dr. A. ROLLIER called attention to certain dangers in the sun bath treatment, and uttered a warning against its haphazard employment, particularly during the midday hours. A conference of medical officers of health reviewed the progress made in the combating of tuberculosis, papers being read by DRS. G. B. DIXON and G. LISSANT COX. Dr. W. M. WILLOUGHBY (medical officer of health, Port of London) contributed a note on the health of crews and ship hygiene, with special reference to tuberculosis. Other subjects discussed at this conference were the Insurance Medical Service and the work of women sanitary inspectors.

England and Wales.

WEST RIDING MEDICAL CHARITABLE SOCIETY.

THE annual meeting of the Medical Charitable Society for the West Riding of York was held recently at Halifax under the chairmanship of the president, Dr. J. Crossley Wright. The report for the year ending June 30th, 1927, shows a continuous growth in the membership and in the beneficent work which is carried on. During the year there had been a loss to the society of twenty-two members from various causes, including the death of ten members. Thirty-one new members were elected, and the year 1927-28 begins with a membership of 927. It was pointed out that at the next annual meeting, which is to be held in Leeds under the presidency of Dr. Barrs, who became a member in 1883, the society will celebrate its centenary, for it was inaugurated at a meeting held on July 25th, 1828, at Turnbull's Hotel, Leeds. Thirty-nine grants, amounting to £1,771, were made for the coming year. The applications are very carefully looked into and the grant in each case is entrusted to the steward of the district concerned for the benefit of the applicant. Since the society was founded down to the year which has just come to a close it has given in grants no less than £77,570, and now has invested funds to the nominal value of £43,181 10s. 1d., of which the purchase price has

been £39,209 7s. 7d. The interesting history of the earlier years of the society, which was written by the late Mr. Wheelhouse of Leeds, one of the most loyal of its supporters, touched upon the economical manner in which the work was carried on. This spirit of economy is still observed, but all reasonable applications are met. The society is a true charity, and it seems desirable to emphasize this; no one who is a subscriber is entitled to any benefit from the society, nor is anyone entitled to anything in respect that he has been a dependant on a subscriber. On the other hand, anyone who, in respect of the rules of the society, is entitled to apply for a grant may do so in the full assurance that his case will be sympathetically and confidentially considered. It was mentioned in the report for the year ending June 30th, 1926, that the income tax authorities had, in the previous year, and for the first time in the history of the society, refused to return the income tax which is deducted at the source from the dividends on its investments. An appeal was made to the commissioners, and the society was represented by counsel. A decision was given in favour of the society. The income tax authorities made no kind of fight at the hearing of the appeal, but obtained powers to state a case for hearing in the High Court. A special meeting of the society was held and it was decided to fight the case. On June 17th, 1926, Mr. Justice Rowlatt gave a very strong judgement in favour of the society, with costs. This action on the part of the income tax authorities has involved the officials of the society in much trouble, and the cost to the society has been upwards of £200.

AN EX-SERVICE MEN'S VENTURE AT LEEDS.

The Tuberculous Ex-service Men's Society, Ltd., was started at Leeds seven years ago to help tuberculous men, so that three, under proper supervision, might be able to do the work of one fit man, and at the same time be able to receive the full trade union rate of wages prevailing in the industry in which they were employed. With an initial capital of £3,000 provided by pooling the men's gratuities, a turnover of £30,000 a year of work by 150 men has been built up, and £70,000 have been paid in wages. The committee of the society now finds it necessary to appeal for funds to place the movement on a sound financial footing, and to acquire premises to provide accommodation for more men. The trades in which the men engage are brush making, printing, joinery, window and other cleaning, and firewood making. The secretary-manager is Mr. G. W. Allen, "The Factory in the Field," Potternewton Lane, Leeds.

LABORATORIES AT VICTORIA PARK HOSPITAL.

The Minister of Health on July 19th opened a new pathological laboratory and research institute at the City of London Hospital for Diseases of the Heart and Lungs, Victoria Park, London. The cost of the establishment has been met by the Prudential Assurance Company; for equipment an anonymous donor has given £500, and the Ladies' Association of the Hospital has raised £400. In his speech the Minister of Health began by referring to his desire to establish in London post-graduate courses, one purpose of which would be to give general practitioners who had been working for some time away from the centre of things the opportunity of learning the latest ideas and methods in medicine and surgery. After observing that pulmonary tuberculosis, heart disease, and diseases of the respiratory system were among the five most deadly diseases, Mr. Chamberlain said that during the last ten years the number of deaths from pulmonary tuberculosis had been reduced from 1130 to 883 per million, respiratory diseases by 34 per cent., and heart disease by 3 per cent. The country was spending over two and a half millions a year upon the treatment of civilian persons for tuberculosis alone. Two methods of reducing this expenditure were open; one was to improve the means of diagnosis, for early recognition of the disease was essential, since treatment during the early stage was of utmost importance; the other method was the acquisition of fresh knowledge by research.

Correspondence.

MEDICAL CHARITIES.

SIR,—Without in the least deprecating the appeal in your issue of July 16th (p. 115) by Drs. Livingston and Wilson to the wealthiest section of the profession for very large subscriptions to the B.M.A. Medical Charities Fund, may I underline even more emphatically their additional reminder to the rank and file, as they phrase it? My own experience may serve to show how difficult it is to arouse medical men (and women) to an appreciation of their duty in this respect. In the last two years I sent seventy-eight autograph letters to practitioners in Kensington whose names did not appear in the subscription lists of either of the two leading medical charities; I obtained in all twelve new subscriptions (for Epsom College), and was inclined to be a little disheartened until an experienced beggar for charity assured me that I had done remarkably well.

My next experience confirmed this view, for I lately undertook to act as charities secretary of the Kensington Division (which covers Hammersmith and Paddington also). In this capacity I have sent out in the last two months 872 circulars, to members and non-members, of a special appeal for the B.M.A. Charities Fund. I have learnt, naturally, that a considerable number of the recipients already subscribe—perhaps forty or fifty; the actual response from the remainder comes to barely £6. I live in hopes of some more cheques arriving; but so far, as anyone can guess, I do not feel proud of the results of my effort. The only argument or excuse I have had put forward was that of a man who said he suspected that doctors who come down in the world do so because they are too idle to get up at night when summoned; and that he did not see why he, who obeyed every call of this sort, should help to support those who would not.—I am, etc.,

HENRY ROBINSON,
Honorary Charities Secretary, Kensington Division,
London, S.W., July 15th. British Medical Association.

LUNACY REFORM.

SIR,—The subject of lunacy reform is fortunately receiving some prominence at the moment. May I quote a case in point in the hope that some of your readers, privately or in their official capacity, may give me some advice as to how to deal with such cases?

A young man presented himself at my consulting rooms. He stated that he had come from a distant colony and that he believed that my friend, Dr. X., had written to me about him. He said that he had discovered an infallible method of communicating between individuals at a distance and even unknown to each other. This method was by psychopathy. He said a good deal more on these lines indicating that he was an advanced paranoic. He appeared to have no friends or relatives in this country, and at a guess I should think that he had very limited means.

What is the duty of the community towards psychotics of this type? And if the community has any duty towards them, who is to be this "brother's keeper"? If nothing is to be done, he reaches the asylum either by becoming so bad as to commit an anti-social act or by his total inability to support himself.—I am, etc.,

London, W.1, July 15th. H. CRICHTON MILLER.

TONSILLECTOMY.

SIR,—The operation for the removal of enlarged tonsils has been frequently commented upon in the pages of the JOURNAL during the last few years, and I venture to make further comments.

1. Is the surgeon justified in performing the operation with the naked hand? I say emphatically No.

2. Is he justified in performing the operation in a theatre after a septic case however well the sterilizing is done? I say No.

3. In these days where so many cases are sent by education authorities to hospital is the operation of dissection justified? I say again No.

I have a record of a series of cases where children have developed acute otitis media afterwards; where this has

occurred it has invariably been after the dissection operation; it has seldom happened, to my knowledge, after the ordinary guillotine operation. The chance of infection through the Eustachian tube is much greater in the dissection operation.

I say that it should not be performed as a routine, and never where the child is sent out of hospital the same day or even within the next day or two.—I am, etc.,

ARTHUR M. BARFORD,
Aural Surgeon, Royal West Sussex Hospital, and to the Portsmouth and Southern Counties Eye and Ear Hospital.

Chichester, June 6th.

ROYAL NAVAL VOLUNTEER RESERVE MEDICAL SERVICE.

SIR,—The letter of "R.N.V.R.," published in your issue of July 9th (p. 80), calls attention to the very marked lack of official appreciation of the war services of the medical branch. One might almost suppose that the policy of the "frozen mitt" had been deliberately adopted by the Admiralty towards these officers. I can quote my own case as an example. After being ten years in the Reserve, five of which were spent on active service, I retired. A vacancy occurred in my district, and I submitted my name for appointment as Admiralty surgeon and agent, more for sentimental reasons than any other, as the financial return would have been trifling. Though there were no other applicants who had served at sea my submission was abruptly turned down. This sort of treatment is scarcely an encouragement to the sacrifice of one's scant leisure which service in the Reserve entails. There was not even an official note of thanks for our services when we were demobilized.—I am, etc.,

July 12th. Ex R.N.V.R.

Medical Notes in Parliament.

[FROM OUR PARLIAMENTARY CORRESPONDENT.]

THE House of Commons this week passed the Finance Bill through Report and Third Reading, and discussed Scottish Estimates.

Landlord and Tenant (No. 2) Bill.

Standing Committee B of the House of Commons devoted considerable time, on July 12th, to consideration of the Landlord and Tenant (No. 2) Bill. An amendment to include in the bill premises used for carrying on a profession was debated, and was ultimately withdrawn in favour of a new proviso restricting compensation to improvements in such premises.

Sir Richard Luce moved to insert in Subsection 1 of Clause 12, after the word "business," the words "or profession." He said that he understood that the Government did not intend to oppose this amendment if there was a definite expression of opinion on the part of a considerable number of persons that the provisions of the bill should extend to professional premises. He desired to speak specially of the medical profession. There was a body of opinion in that profession in favour of being included. The British Medical Association had passed a resolution to that effect. There was also a considerable demand from dentists to be included, and he was glad that the Government, through the Home Secretary, had promised that this matter should be left to the free vote of the Committee. The relation of a doctor or a dentist to the premises where he did his work was important, and if he was turned out it was just as important to him as to a shopkeeper. A doctor might have to improve his premises for professional purposes. In some instances he had to build premises under the direction of the Insurance Act Committee to provide suitable accommodation for his patients, and he often had to build a garage solely for the purpose of his practice. Such improvements must be of value to the house in letting it to a doctor on another occasion. There was therefore no reason why professional premises of this kind should not be added to the bill on the same footing as shops and business premises.

Mr. MacLaren said he was sure that the Home Secretary would agree that there were certain people who might be termed professional men who would suffer severely under the strict lines of the original bill. He therefore wished to support the amendment.

Sir P. Pilditch hoped that both the Home Secretary and the Committee would be careful in giving support to this amendment because it meant a very large extension of the bill. The speeches made in its favour had referred mainly to doctors, but what he intended to say applied much more largely to other classes of professional men. He did not know whether the amendment would open the door to professional men getting compensation for physical improvements made, and to the whole question of compensation for goodwill. There was something to be said in the matter of improvements but nothing with regard to goodwill. The theory that it was possible for a professional man to have acquired the class of goodwill which this bill was going to cover was absurd; the goodwill to be compensated for was goodwill which remained appurtenant to the premises. Could anyone imagine that any doctor or other professional man could have created goodwill which he could not take away with him when he left the premises? The great extension this amendment would bring about was not justified, because it would do away with the real intention of the bill, which was never meant to extend to private residences. In Harley Street and other similar streets three or four doctors might carry on their profession in the same house. Every one of them would, if this amendment were adopted, have a claim for compensation, not only for improvements, but also for goodwill, and they would get a set of circumstances which would make the work of the tribunal almost unthinkable.

Major Crawfurd said that Sir P. Pilditch seemed to have advocated a very dangerous principle. The Committee was not sitting to help particular classes of people, but to establish certain principles of law, and if more than one class came under the same principle it should be extended to those other classes as well. What was the difference between the position of the professional man, such as the doctor, and the retail shopkeeper in respect to this principle?

Mr. G. Jones said that if it was right that a man who spent money on improvements should be compensated, and that a man who built up a goodwill should also be compensated, he could not see why that principle should not be extended to the professional man. The amendment was an attempt to help doctors and other professional men, and to prevent them from being victimized in the way that tradesmen had been victimized in the past.

Mr. Womersley said that his invariable experience had been that when a man required certain premises for professional purposes, the owner asked more rent than he would charge to a private resident. He had handled many such cases, in which there had been a row of houses, and when a doctor came along looking for premises to carry on his profession the rent had been put up against him. The doctor or the dentist had a right to be compensated to such an extent as the tribunal might decide.

Sir M. Manningham-Buller said that no definition had been given of a profession. The profession of a doctor was one in which there was a very strong case for compensation for improvement. In regard to the question of goodwill in connexion with the medical profession, an entirely new outlook was required as to what was a doctor's goodwill. Was the practice which a country doctor had to be looked upon as goodwill? If the doctor was unable to get a fresh lease, was he to get compensation for what he had paid for his practice? He thought that that was a view that some doctors were inclined to take. But if, in a country district, a landlord knew that, if he let premises to a doctor, he might be rendered liable to pay the doctor the whole of the amount that he paid for the practice, the doctor would find it very difficult to get a house. If the whole of the professions were going to be embraced in the bill, consideration would have to be given to the many different and conflicting views as to what the goodwill, not only of a doctor, but an auctioneer or surveyor, and so on, would be. If the amendment were one to allow the payment of compensation for improvements made by such people as doctors and dentists, it would have his support. If, however, it opened up the question of compensation for all the various degrees and forms of goodwill throughout all the varying professions, which were not even yet defined, the bill might be overloaded and made unworkable. If that were to be the result of supporting the amendment he should vote against it.

The Home Secretary said that he would not ask the Committee to decide one way or the other on the terms of the amendment, but he would put his views before the Committee. He thought that the amendment clearly brought all professional men, both for improvements and for compensation, within the scope of the bill. That was carrying the bill considerably further than hitherto. Having been a professional man himself for a good many years, he thought that the type of goodwill in a professional man's business, so to speak, was not the same as in a tradesman's business. He had moved from one part of London to another, and it had made no difference to the value of his goodwill. The bill did not deal with the goodwill of the tenant, but with the pecuniary advantage which the landlord got at the end of the tenancy by the fact that a particular trade or business had been carried on in the house in question. He did not think that the fact that he had carried on the trade of a lawyer or Sir R. Luce the trade of a doctor in a particular house was really going to bring in any more patients or persons desiring legal advice to that house after the lease was over if another doctor or lawyer took it. Therefore the landlord would not get very much advantage from the fact that the business of a lawyer, or doctor, or sculptor had been carried on in the premises in question. To go into all these questions, as to what the landlord had received by reason of the fact that a lawyer, doctor, or sculptor had carried on his profession in the particular premises would complicate the bill very much and would make it very much more difficult. There was more to be said for the proposal in the amendment with regard to improvements. A doctor in premises in the country might want to put up a garage, or a panel doctor in the East End of London might think it necessary to enlarge his surgery. Either would be just as much an improvement as when a tradesman desired to enlarge his shop front, and so on. As representing the Government, he did not propose to take part in the division on the amendment, but he wondered whether Sir R. Luce would accept a suggestion from him, and whether the Committee would agree to give professional men something, but perhaps not quite all, that they asked for. If the amendment were pressed there was likely to be a strong division of opinion in the Committee, and the matter might ultimately have to go to the House to be

fought over again. The Committee might get out of the difficulty by confining the idea underlying the amendment to the earlier part of the bill, and by adding, at the end of Subsection (2 *b*) these words:

> "Provided that, so far as this part of this Act relates to improvements, premises used for carrying on a profession shall be deemed to be premises used for carrying on a trade or business."

That would go a long way to meet the views of the doctor, or even the sculptor, and would be a reasonable amendment. If it were generally accepted by members who opposed altogether any extension of the bill, and by those who wanted to extend it further, he thought it would certainly be accepted by the medical profession, and that the House of Commons would say that the Committee had come to a wise and sensible decision in the matter.

Sir G. Hohler said that the amendment was inconsistent with the language of clauses of the bill which had already been passed. The language of Clause 4 in regard to the goodwill of a trade or business was quite inapplicable to the profession of a doctor or surgeon, or solicitor or barrister. The amendment sought to extend the bill to every private residence. If the amendment were accepted the gravest difficulties would arise. A landlord would be called on to pay goodwill to a doctor, but what would be the value of that goodwill to him? The landlord would never know what he had to pay.

Sir R. Luce said that he could not admit that there was no goodwill in the case of the professional man. In certain circumstances there was goodwill arising out of the place itself, and quite apart from the goodwill of the doctor, which had been built up by his professional ability. A doctor might settle in a town and convert a house into a place which became well known as a doctor's house. In many cases those houses went on from generation to generation. After what the Home Secretary had said, he was prepared to leave the matter in his hands entirely. On the understanding that the Home Secretary would move the amendment he had indicated, he (Sir R. Luce) would withdraw his amendment.

Sir R. Luce's amendment was accordingly withdrawn.

Sir W. Joynson-Hicks then moved the amendment which he had already outlined in his speech. He said that the wording might be a little awkward, and it might be necessary later to pull the clause together a little. At any rate, the amendment brought a profession within the scope of the bill. He regarded it as a fair compromise. He took it that the Committee would be prepared to accept it as a whole, though he did not want to force it in any way. The Home Secretary's amendment was agreed to.

Home Office Vote.

The House of Commons discussed, on July 14th, the estimate of £257,647 for the Home Department in 1927-28. Mr. Rhys Davies, opening the debate for the Labour party, said that among 6,000,000 workpeople engaged in factories and workshops there were each year 1,000 fatal accidents and about 170,000 non-fatal accidents. These numbers were not declining. The public was apathetic, although the "Safety First" propaganda had in some factories brought very good results. Factories were more numerous and diversified than ever, but this country had fewer factory inspectors than before the war. About 207 inspectors in Great Britain had to visit 290,000 factories; Germany had 642 inspectors for 335,000 establishments. Enlightened employers already had medical staffs in their factories, and the laggards should be brought up to the position of the best. Mr. Davies asked what methods were adopted to enforce the new regulations as to the use of white lead paint and to what extent wet rubbing-down was now used. He declared that miners' nystagmus was increasing, and asked whether the arrangement made in 1924 for employing affected miners above ground was being observed. He desired to know whether there were means of applying the Workmen's Compensation Act to cases of steel-smelters' cataract, which developed after men left the steelworks for other employment.

Mr. Tinker drew attention to the new Order under the Workmen's Compensation Act regarding "miners' beat-knee" and "miners' beat-elbow." He complained that by introducing the word "acute" a miner was compelled to carry on till totally incapacitated before a surgeon could grant a certificate.

Mr. Hilton contested Mr. Rhys Davies's suggestion that every large mill should have a medical staff. Every large town had an up-to-date medical staff in the local infirmary in the centre of the industrial area. Medical men in these infirmaries took great interest in mechanical accidents and had a localized knowledge.

Mr. Robinson asked what was being done by the Committee inquiring into dangers to health caused by dust and fibres, and suggested that next winter inspectors should pay more attention to cold rooms in factories.

Dr. Vernon Davies said that many thought a retrograde step had been taken when, to save £7,000 a year, the inspection of accidents was taken away from the certifying surgeons, who previously had to go to the mill and see the machine where the accident happened. Now all that the certifying surgeon had to do was to go to the office and certify, and he practically never went into the mill, where under the old system he could draw attention to defects. The medical man's knowledge, in co-operation with that of the medical inspector, could be a great help, and he asked the Home Secretary to consider entrusting again the inspection of accidents to the certifying surgeon.

Mr. Compton asked why cattle ringworm had not been scheduled under the Workmen's Compensation Act. Dermatitis among french polishers and lithographic workers also required the consideration of the Home Secretary.

Mr. Paling hoped the Home Secretary would make inquiries into the possibility of scheduling silicosis in coal mines, a step which the Miners' Federation had requested for years. Stone drilling machines, which had lately been introduced in coal mines, gave off fine dust, and in the opinion of doctors men working with them were as liable to contract silicosis as were men in silica mines. He suggested that boys should be examined to see whether a tendency existed to nystagmus and excluded from the pits if it did. Did not the Home Secretary think sufficient evidence had accumulated to justify another committee of inquiry into nystagmus?

Sir William Joynson-Hicks, replying to points raised, said that compensation claims for such diseases as steel-smelters' cataract must at present be made within a year of termination of the employment which produced the disease. To extend this period would require an Act of Parliament. Although the number of factory inspectors had been reduced since 1913 from 222 to 205, the number of visits to factories had gone up. There had been fewer visits to workshops, and he admitted there was a case for more factory inspectors. Undoubtedly many thousands of works were not inspected each year, but the Home Office was limited by the Government's strenuous effort for economy. He was asking the present staff of factory inspectors to work harder, and they were responding gallantly. No evidence had been put before him that cattle ringworm in mankind would normally prevent a man carrying out his work. Whether he would be endangering the health of others by working was an entirely different point. The Ministry of Health was undertaking a special investigation into this disease, and he must await the result before saying whether the disease would be scheduled. Miners' nystagmus caused the Home Office anxiety. In 1908 there were 386 new cases and 74 old cases; in 1924 3,445 new and 7,890 old. The Medical Research Council in 1923 made recommendations, including one for altering the terms under which the disease had been scheduled. A scheme had been drawn up by the Home Office giving effect to these recommendations, but the Miners' Federation had not yet stated its views on it. With regard to miners' beat-knee and beat-elbow, the point he had to consider was how far bursitis without inflammation incapacitated a man. The Medical Research Council had found that chronic enlargement of the bursae in front of the knee or elbow did not cause incapacity. If members, or the Miners' Federation, would bring medical evidence that a bursitis not associated with acute inflammation disabled the worker he would reconsider the decision.

Dr. Vernon Davies, intervening, asked for a definition of "acute" in bursitis. Sir William Johnson-Hicks quoted the Medical Research Council's declaration that "The certifying surgeon must always satisfy himself that the condition is an acute inflammation arising out of the workman's employment and of sufficient severity to cause loss of earning power."

Dr. Davies said that under that definition a man would have to be incapacitated from work for many days before the certifying surgeon could give a certificate. The Home Secretary offered to consider any medical evidence which Dr. Davies could give and to make any further inquiry necessary to satisfy the Miners' Federation. Though silicosis was not scheduled, compensation could be provided for it under the Workmen's Compensation (Silicosis) Acts if in any industry or group of industries there should be a scheme for provision of compensation. He had made a scheme for the refractories industries (ganister mining, and ganister and silica brickworks, and quarries), and another scheme for the metal grinding industry (the grinding of cutlery and edged tools, machinery, etc.). The former scheme was working satisfactorily; the latter had just come into force and was not altogether popular, though employers had entered whole-heartedly into the working of the schemes. The Home Office and the Mines Department had conducted a medical inquiry into silicosis in coal mines, and had examined men by *x* rays. Tests and information had shown distinct evidence of silicosis in the lungs of these men. Thirteen men were found affected in one mine or group of mines, and in two or three cases very serious fibroid conditions were found by radiographic examination. Yet the owners of the coal mine, with whom he had conferred on the previous day, had denied that there was any silica in the mine. He was satisfied that the disease existed, and he had arranged that the Mining Association representatives should interview the medical advisers of the Mines Department, who had arranged for the examination of the affected men by doctors of the highest eminence. If the Mining Association was not convinced he must set up an inquiry, and, if then satisfied, would make an Order for the mining industry. He had had a large number of mines examined by an independent medical expert from South Africa. He declined to discuss lead paint again; there had not been time to find out how far the wet process was really being carried on.

The Vote was agreed to, as was a subsequent vote of £503,901 for prisons in England and Wales.

Bills Advanced.

On July 15th the House of Commons read the Poor Law Bill and the Diseases of Animals Bill a third time, and the Destructive Insects and Pests Bill a second time. The first is a consolidating bill. The second deals with the testing of imported cattle for disease, with the destruction of infected cattle in this country, and with compensation for such destruction. The third provides for the destruction of infested crops. On the Diseases of Animals Bill Mr. A. V. Alexander said that milk tests showed a real danger from tuberculosis in our herds. Dr. Nathan Raw had said that he had over 2,200 patients whose tuberculosis was caused by infected milk, and that 15 per cent. of all milk supplied contained living tubercle germs. The Chairman said that this was irrelevant to the bill. Mr. Guinness said that between September 1st, 1925, and March 31st, 1927, owing to notification of tuberculosis on farmers' premises or to the tracing back of

tuberculous milk, premises were inspected housing 1,051,000 cattle, a seventh or an eighth of the cattle in the country. Of these, 792,000 were cows and heifers, among whom 21,871, or 2.7 per cent., were suffering from the forms of tuberculosis which brought them within the Tuberculosis Order—tuberculosis emaciation, chronic cough, and tuberculosis of the udder. The last, by far the most serious danger, only occurred in 0.5 per cent. The figures quoted by Mr. Alexander were terrifying but unfounded.

In the House of Lords, on July 18th, the Midwives and Maternity Homes Bill (Scotland), and the Medical and Dentists Act Amendment Bill were read a second time. The last is a measure which is to confirm and give effect to certain agreements between representatives of Great Britain, the Irish Free State, and Northern Ireland as to the registration and control of medical practitioners and dentists, and to validate certain acts done by the Dental Board.

Pensions Vote.

On July 16th Colonel Stanley introduced estimates of £38,242,832 for the Ministry of Pensions in 1927-28. He said nearly every item was subject to uncontrollable factors. The Ministry could not tell how many pensioners or dependants were likely to die during the year. A bad winter might cause more sickness among pensioners and send them to hospital. The administrative cost of the medical services of the Ministry was estimated at £298,700. The Ministry was asking £2,507,500 for the benefit side—a decrease of 8 per cent. Nearly half the cost of medical treatment was due to mental cases, the number of which remained fairly constant. The need for hospital treatment was diminishing, but in a number of cases the ailments were liable to recur, and for this reason hospital accommodation must be retained for some years. It was calculated that this year there would be an average of 14,000 in-patients, medical as well as surgical, against 15,000 last year. This year 60,000 child dependants ceased to be eligible for allowances. Last year 4,500 widows remarried. In round figures there were now 1,000,000 pensioners and 650,000 dependants.

Major Cohen argued for the removal of the seven-year limit on claims for pensions. The British Legion put this claim forward particularly for tuberculous cases and for troubles arising from gas poisoning. The limit had been fixed when no data were available.

Dr. Drummond Shiels said that Circular 30, on which the doctors had to work at present, involved a difficult procedure and was not known to the ex-service man, though doctors in hospitals sometimes told the men of their right to claim revision. Where men during the war suffered from malaria, bronchitis, or other diseases, ordinary ailments subsequently tended to take a more serious form and the men ran much greater risk of death. Why should there be discrimination when death was not wholly due to war disability? Some of the finest men in the army, who carried on in spite of physical disabilities, were penalized by a narrow book-keeping outlook. Other members also cited cases in which tuberculosis, claimed to arise from war service, had not been pensioned. Mr. Naylor suggested that the Minister should advise doctors in hospitals, when they had to certify the death of pensioners who had been under panel doctors, to consult first with those doctors. Sir Walter Greaves-Lord said medical men were constantly finding that the origins of disease were much further back than they had thought. This was so in regard to neurasthenia. When that malady came on after a long period it was worse from the point of view of disablement. There were grounds for reopening a great number of these cases.

Major Tryon said Dr. Shiels was wrong in suggesting that changes made from time to time in warrants had been to the disadvantage of the pensioners.

The debate was adjourned.

Pollution of Rivers.

In the House of Lords, on July 18th, Lord Mildmay of Flete opened a debate on pollution of rivers. He said that last February a deputation waited on the Lord President of the Council and urged that a central authority should be established to control inland waters, and that local river boards should be created in support of that central authority. It urged also the necessity for scientific research to solve the innumerable problems attendant on the abatement of pollution. Something more was required than research. The Government ought to take action. The Earl of Balfour said the Government had appointed an Advisory Committee representing the Ministry of Health and the Fishery Board. The chairman would be Sir Horace Munro. The Committee would advise on new legislation, on the setting up of new river boards, and on inducing local bodies to co-operate with each other. A Committee now at work, composed of men of science, would carry on research into the pollution of rivers.

Research in East Africa.

During the discussion of the Colonial Office Vote in the House of Commons Captain R. R. Henderson called attention to the research into leprosy in Uganda. It did not involve a large sum of money, owing to the advance of medical knowledge and medical research which had made it possible to attack the disease effectively. He hoped that the special commission which had been set up to inquire into the federation of East Africa would be asked to direct its attention to the possible co-operation of East and West Africa in all the forms of research relating to the tsetse fly.

Mr. Amery, in reply, said that perhaps the greatest problem of all in East Africa was that of research. The problem of the tsetse fly was being coped with in conjunction with the League of Nations, and it was hoped to carry the matter further in co-operation with the Governments concerned. These problems, including that of research into leprosy in Uganda, concerned the whole of East Africa, and that was one of the reasons why administrative unity was desirable.

Lead Paint (Protection Against Poisoning) Act, 1926.

In the House of Commons, on July 19th, Mr. Harney asked leave to introduce a bill to remove the prohibition contained in the Lead Paint (Protection Against Poisoning) Act, 1926, against the employment of women in painting buildings with lead paint. He said the bill would place women on exactly the same footing as men by allowing them to engage in the industry under the regulations laid down in the Act of 1926. Miss Bondfield opposed the bill. She said that the regulations were not satisfactory, but if men preferred to go on being poisoned that was no reason why women should consent to be poisoned. Leave to introduce the bill was refused, without a division.

Medical Adviser to the Mines Department.—On July 19th Colonel Lane-Fox informed Mr. Lunn that the last date for receiving applications for the appointment of the new medical adviser to the Mines Department was July 31st. After that the qualifications of the applicants must be carefully considered. The appointment could not be made for some time, but would be announced as soon as possible.

Lunacy Administration in the Sudan.—Mr. G. Locker-Lampson told Mr. Pethick-Lawrence, on July 19th, that there were no regular lunatic asylums in the Sudan. Mild cases of insanity in Europeans were dealt with in the hospitals. Violent or dangerous cases were sent to Cairo as soon as possible, being admitted to an institution on arrival. Cases of insanity amongst the Sudanese were always, when possible, sent to their homes, recourse being had to hospitals, prisons, or such accommodation as was available locally, only in violent or dangerous cases.

Notes in Brief.

No cases were now outstanding in which approved societies had failed to submit the books for audit.

Earl Winterton, on July 18th, stated that the Government of India had decided that an inquiry into the opium traffic in India was unnecessary.

Sir Kingsley Wood stated, in reply to a question on July 18th, that plague-infected rats had been found in the s.s. *Plutarch*, which brought a cargo of grain to the Victoria Dock, London. Measures taken by the port sanitary authority included the mooring of the vessel in the middle of the dock and its fumigation for the destruction of the rats. The unloading of the vessel was later completed under the supervision of the officers of the port sanitary authority.

Obituary.

SIR EDMOND SINCLAIR STEVENSON,

M.D., F.R.C.S.Ed.,

Late President of the Medical Council, Cape Colony, and Honorary Vice-President, British Medical Association.

We have already recorded with deep regret the death of Sir Edmond Sinclair Stevenson, at the age of 76, at his residence in Rondebosch, near Capetown.

Sir Edmond Stevenson received his early education in Geneva, where he was born. He later studied medicine at the Sorbonne in Paris, but on the outbreak of the Franco-Prussian war he joined the French ambulance. He then resumed his medical studies and worked in Edinburgh, St. Thomas's Hospital, and King's College, London, obtaining in 1873 the diplomas M.R.C.S.Eng. and L.R.C.P.Ed. In the following year he became F.R.C.S.Ed., and in 1894 he graduated M.D.Brux., with honours. He went out to South Africa in 1873 and commenced practice at Philadelphia, in the Malmesbury district, but soon afterwards removed to Rondebosch. In 1892 he was nominated a member of the Colonial Medical Council, of which he was elected president in 1897; from 1900 to 1909 he represented the medical profession on the Council. In spite of impaired health he volunteered for military service at the outbreak of the late war, and was placed in charge of a hospital in South Africa, with the rank of lieutenant-colonel. In 1916 he was gazetted lieutenant-colonel, S.A.M.C., and was attached to the Alexandra Hospital.

He took a prominent part in the foundation of the Cape Branch of the British Medical Association in 1893, and was its president in that year and also in 1904. He presided over the South African Medical Congresses of 1894 and 1900.

In addition to conducting a large general practice, his patients including such well known men as Cecil Rhodes, Sir Gordon Sprigg, and Sir William Cameron, he took special interest in surgery and gynaecology.

Universities and Colleges.

UNIVERSITY OF OXFORD.

Theodore Williams Scholarship in Pathology.

THE Theodore Williams Scholarship in Pathology has been awarded to Joyce Wright, B.A. (Somerville College), and J. G. Reid, B.A. (University College), whose work was of equal merit.

UNIVERSITY OF BIRMINGHAM.

THE following candidates have been approved at the examinations indicated:

M.B., CH.B.—W. B. Ballenden, St. C. H. Baynes, E. L. Butler, H. E. Carmalt, A. S. Esslemont, *K. P. Fooks, Helen G. Gifford, F. E. Hampton, S. Hobson, R. L. Jones, †Marjorie V. Martin, Marjorie H. Mills, Margaret Mitchell, Phyllis M. Paddock, ‡Mary E. Percy, S. H. Reeves, A. H. Richardson, V. H. Sarland, A. Sirry, Frances M. Stockdale, Olive F. Sydenham, A. D. Tomlins, F. Welsh.

* Samson Gamgee Memorial Medal for surgery.
† Distinction in medicine and Arthur Foxwell Memorial Medal in medicine. ‡ Queen's Scholarship.

UNIVERSITY OF LEEDS.

THE following candidates have been approved at the examinations indicated:

FINAL M.B., CH.B.—*Part I*: D. W. E. Burridge, M. Goodman, A. Milner, J. R. O'Neill, Mary G. Shawe, L. Smith, Ivy R. Watson. *Part II*: M. Abrams, C. R. Adgie, F. V. Allen, J. Benson, G. F. Bramley, J. Caplan, W. Chalmers, D. J. Clarke, J. W. L. Crossfill, A. Dalby, M. M. Dey, G. A. Dibb, Mildred I. Ealing, L. Godlove, F. Grundy, R. C. Hanson, L. I. Hardy, W. L. Hoole, J. H. Kahn, R. H. Kipping, A. M. Korn, W. E. L. Lawson, W. Levi, R. H. Olver, A. B. Pain, J. Phillips, R. J. H. Raines, A. Robinson, G. S. Seed, Edith A. Shuttleworth, V. P. Squire, Ella B. Sykes. *Part III*: *D. W. Currie, *J. Phillips, †G. F. Bramley, †G. A. Dibb, †F. L. A. Hughes, †A. B. Pain, M. Abrams, G. H. Carr, W. Chalmers, D. J. Clarke, J. W. L. Crossfill, L. I. Hardy, W. L. Hoole, R. H. Kipping, A. M. Korn, J. G. Ollerenshaw, R. H. Olver, Marjorie M. Readman, A. Robinson, G. S. Seed, Edith A. Shuttleworth, Ella B. Sykes, ‡Emily E. Johnson. SECOND M.B., CH.B.—*Part II, Pharmacy*: T. G. Clarke, H. T. Knowles, E. J. Wayne. *Pharmacology*: Bessie Brown, W. H. Craven, H. Denton, F. B. T. Drake, W. R. Everatt, C. H. Foster, J. F. Galpine, R. W. Golsborough, W. L. Hardman, J. N. Hill, G. Hirst, G. M. Holliday, L. Hoyle, Eugenie C. Illingworth, I. J. Keidan, R. G. S. Meadley, C. Poniedel, L. J. Richmond, S. Rosenberg, L. Silverman, M. I. Silverton, W. E. Smart, E. J. Wayne, J. W. Whitworth. *Part III*: G. M. Holliday, J. Rabinovitch, M. Rooms, S. Silman.

* First-class honours. † Second-class honours.
‡ Distinction in medicine.

UNIVERSITY OF LIVERPOOL.

AT the annual graduation ceremony on July 9th the following degrees were conferred:

M.D.—W. Emdin, S. M. Katz, J. A. Scott.
M.B., CH.B.—*W. S. Brindle, *J. McHugh, *S. P. Meadows, *A. D. Polonsky, †J. K. Cameron, †A. Dodd, †P. H. Whitaker, †R. L. Wynne.

* First-class honours. † Second-class honours.

UNIVERSITY OF EDINBURGH.

AT a graduation ceremonial in the M'Ewan Hall on July 14th the following degrees were conferred and prizes distributed:

M.D.—‡Harriette G. Bogle, ‡Gladys H. Dodds, *J. Gray, *R. G. Inkster, †G. M. Lamb, *C. G. Lambie, F. W. Lang, †O. J. S. Macdonald, Ella G. F. MacKenzie, Rosanna E. Macmillan, ‡A. J. Muirhead, ‡J. R. K. Paterson, ‡Elsie Porter, G. W. Simpson, J. A. B. Young.

M.B., CH.B.—J. P. Bannerman, N. Baxter, R. L. Beveridge, W. K. Blackie, §J. D. Bottomley, J. Brown, T. G. Brown, J. A. Bruce, W. N. Campbell, L. G. Carmichael, D. C. Chopra, W. F. H. Coulthard, E. C. Davies, J. B. Dedman, A. W. Dunn, G. H. Duthie, A. C. Edwards, J. C. S. Edwards, Hannah M. M. Elder, G. Erskine, I. B. Ewart, I. J. Freedman, Mavis E. Furst, G. W. Gale, C. O. Gange, H. P. S. Gillette, A. L. Goldberg, E. W. Graham, S. H. Graham, H. W. Gray, G. A. H. Gumley, O. K. G. Guyer, A. P. Harris, R. M. Hill, Dorothy Hunter, §J. R. Innes, W. M. Innes, §A. S. Johnstone, H. D. G. Jones, B. D. Khurana, A. L. Knipe, S. Kramer, D. G. L. Lackie, A. A. Learmont, G. A. Lee, M. E. Lemin, Mary L. Liston, Isabella M. B. Livingstone, J. W. Lusk, K. S. Macdonald-Smith, I. B. K. MacGregor, R. M. M'Gregor, R. S. MacHardy, D. W. D. MacLaren, §Wilhelmina M. G. MacLennan, I. M. Macleod, §J. M'Michael, A. A. MacNair, D. R. Maitland, R. S. Manson, Edith M. Martin, T. R. Matson, H. Mercer-Ricketts, B. de la H. Meyer, T. C. Mitchell, W. J. Mowat, C. E. Munro, Pauline V. Murray, D. P. Nath, H. J. Nicholson, N. J. Nicholson, J. H. Nicolson, W. J. Officer, Beatrice M'P. Ogilvie, Katharine M. Ogilvie-Mullan, J. D. W. Pearce, W. R. Playfair, G. L. Reid, Hannah M. Reid, §T. M. Reid, §W. A. Robb, J. E. Robson, B. Rogoff, A. W. Rose, Jessie I. Rosie, W. A. R. Ross, R. Sampson, P. N. L. Seager, H. M. Shenkin, A. M. H. Shirazi, Frances E. Smith, Georgina M. H. Somerville, K. H. Teik, D. Tennant, T. P. Thomas, Margaret Venters, E. A. Watson, J. Weinstein, L. Whitten, B. Williams, C. H. Wilson, M. R. Wilson, G. M. M. Wright, Cecilia E. L. Wyllie, G. M. Yates, A. L. Young, J. H. Young.

The following Fellowships, prizes, etc., were presented:

Cameron Prize in Practical Therapeutics: F. G. Banting, M.C., M.B., D.Sc., LL.D. Straits Settlements Gold Medal: G. Buchanan, M.D. Ellis Prize in Physiology: M. H. Finkelstein, B.Sc. Gunning Victoria Jubilee Prize in Anatomy: D. Mainland, M.B., Ch.B. Gunning Victoria Jubilee Prize in Medicine: R. V. Christie, M.B., Ch.B. Lauder Brunton Prize in Pharmacology and Therapeutics: G. H. Percival, M.B., Ch.B. Ettles Scholarship and Leslie Gold Medal, Allan Fellowship in Clinical Medicine and Clinical Surgery, Murchison Memorial Scholarship in Clinical Medicine, Murdoch Brown Silver Medal in Clinical Medicine, and Pattison Prize in Clinical Surgery: J. M'Michael, M.B., Ch.B. M'Cosh Graduates and Medical Bursaries: W. A. Robb, M.B., Ch.B. Mount Scholarship in the Practice of Physic and Beaney Prize in Anatomy and Surgery, J. D. Bottomley, M.B., Ch.B. Buchanan Scholarship in Gynaecology: D. G. L. Lackie, M.B., Ch.B. James Scott Scholarship in Midwifery, Scottish Association for Medical Education of Women Prize, and Dorothy Gilfillan Memorial Prize: Wilhelmina M. G. MacLennan, M.B., Ch.B. Conan Doyle Prize: G. W. Gale, M.Sc., M.B., Ch.B. Annandale Gold Medal in Clinical Surgery: T. M. Reid, M.B., Ch.B. Royal Victoria Hospital Tuberculosis Trust Gold Medal: K. S. Macdonald-Smith, M.B., Ch.B. Wightman Prize in Clinical Medicine: I. Aird. Wellcome Medals and Prizes in the History of Medicine: J. D. A. Gray (gold medal), G. W. Gale (silver medal). Cunningham Memorial Medal and Prize in Anatomy: A. C. P. Campbell. Whiteside Bruce Bursary: T. H. Brown.

* Awarded gold medal for thesis. ‡ Commended for thesis.
† Highly commended for thesis. § Passed with honours.

The degree of Doctor of Philosophy in the Faculty of Medicine was conferred on G. H. Percival, M.B., Ch.B.

UNIVERSITY OF ABERDEEN.

DR. J. A. MACWILLIAM, F.R.S., Regius Professor of Physiology in the University of Aberdeen, has notified his intention of retiring from that chair, which he has held since 1886. He is a graduate of Aberdeen, and has devoted special attention to the physiology of the heart and arteries, the action of chloroform and ether, and blood pressure. Many of his papers have been published in the *Proceedings of the Royal Society*, and not a few in our own columns.

NATIONAL UNIVERSITY OF IRELAND.

Death of Mr. O'Higgins.

A MEETING of the Senate was held on July 15th. The following resolution of condolence was passed unanimously:

> The Senate of the National University of Ireland, associating itself with the expression of profound loss sustained by the death of Mr. Kevin O'Higgins, begs to tender to Mrs. Kevin O'Higgins, B.A. (Higher Diploma in Education), its deep sympathy in the loss inflicted on herself and on her children by the murder of her distinguished husband, himself a graduate of our University in the Faculties of Arts and of Laws: and desires to place on record its reverent appreciation of the noble and Christian spirit so splendidly evinced by him in those hours of supreme trial and suffering.

French Medical Congress.

The Senate appointed William Doolin, M.B., B.Ch., B.A.O., to act as representative of the University at the nineteenth French Medical Congress to be held in Paris in October.

University Calendar.

The *Calendar* for 1927 of the National University of Ireland contains an account of the establishment and constitution of the University, its regulations, constituent colleges, and various examinations. The names of the successful candidates in the examinations held in 1926 are published, and lists are given of the professors, lecturers, graduates, and diplomates of the University.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

A QUARTERLY Council meeting was held on July 14th, when the President, Sir Berkeley Moynihan, Bt., was in the chair.

Elections to Council.

The President announced the result of the poll for the election of three Fellows into the Council, as reported in our last issue (p. 117).

Sir Cuthbert Wallace and Mr. Hugh Lett were introduced and took their seats in the Council.

Re-elections of Officers.

Sir Berkeley Moynihan was re-elected president and Sir Cuthbert Wallace and Mr. F. Steward were re-elected vice-presidents for the ensuing year.

The following were also re-elected for the ensuing year: Physiological Curator, Mr. R. H. Burne; Pathological Curator, Mr. C. F. Beadles; Honorary Curator of the Odontological Collection, Sir Frank Colyer.

Sir John Bland-Sutton.

Sir John Bland-Sutton was asked to present, on behalf of the College, an address of congratulation to the University of Toronto at the commemoration, on October 6th, 1927, of the centenary of the granting of the Charter of King's College, Toronto, now the University of Toronto. The best thanks of the Council were given to Lady Bland-Sutton for presenting to the College the portrait by the Hon. John Collier of Sir John Bland-Sutton, Bt., Past President of the College.

Diplomas.

Diplomas were granted, jointly with the Royal College of Physicians, in psychological medicine to 12 candidates, in laryngology and otology to 12 candidates. The diploma of Fellowship was granted to Mr. R. A. Brews and that of membership to Miss P. M. Robottom, these candidates having complied with the regulations. Licences in dental surgery were granted to 47 candidates.

First Fellowship Examination.

A report was read from the Board of Examiners in anatomy and physiology for the Fellowship stating that at the recent examination 185 candidates were examined, of whom 60 were approved.

Museum.

It was decided that the Museum should be closed during August as well as during September, and for such part of July as may be found necessary for the purpose of redecorating. The President

reported that steps were being taken to transfer the Strangeways collection of specimens illustrating osteo-arthritis from Cambridge to the College.

Paying Patients in Hospitals.

Mr. McAdam Eccles was appointed to give evidence before a special committee, appointed by the Prince of Wales, "to inquire and report to King Edward's Hospital Fund for London upon the question of hospital accommodation in London for persons prepared to pay more than ordinary voluntary hospital patients; and to report the conclusions at which they may arrive.

Endowment for Annual Dinner.

An offer from Mr. Buckston Browne to present to the College a sum of £5,000 to provide an annual dinner to be given on the College premises to Members, Fellows, and others, was accepted with cordial thanks.

Lecturers.

Professors and lecturers were elected for the ensuing year. The following is a list, with the subjects in parenthesis:

Hunterian Professors.—E. M. Atkinson (The pathology, diagnosis, and treatment of abscess of the brain); Sir Arthur Keith (Six lectures on disorders of growth); P. Sargent (The surgery of the posterior fossa of the skull and its contents); J. H. Sheldon (An undescribed disease of bone); H. S. Souttar (Recent advances in cerebral surgery); G. Grey Turner (The treatment of congenital defects of the bladder and urethra by implantation of the ureters into the bowel); W. E. M. Wardill (Cleft palate, with observations on the causes of defective speech and their remedy).

Arris and Gale Lecturers.—A. Abrahams (The physiology of violent exercise in relation to overstrain); A. Fleming (Lysozyne, a bacteriolytic ferment normally present in tissues and secretions); I. C. Mann (The comparative embryology of the vertebrate eye).

Erasmus Wilson Lecturers.—W. D. Newcomb (The relationship between peptic ulceration and carcinoma of the stomach); C. E. Shattock (Pathological specimens in the Museum); C. P. Wakeley (Surgical diseases of the salivary glands).

Arnott Demonstratorship.—Sir Arthur Keith (Six demonstrations on the contents of the Museum).

ROYAL COLLEGE OF PHYSICIANS OF EDINBURGH.

A QUARTERLY meeting of the Royal College of Physicians of Edinburgh was held on Tuesday, July 12th, the President, Dr. G. M. Robertson, in the chair.

Fellowship.

Dr. Alfred Irving Shepheard-Walwyn (Carlisle) and Dr. Walter Duncanson Chambers (Perth) were introduced and took their seats as Fellows of the College. Dr. Robert Victor Morrison (Rangoon), Dr. William Macrae Taylor (Edinburgh), Dr. Douglas James Ackworth Kerr (Edinburgh), Dr. William Alister Alexander (Edinburgh), and Dr. Thomas Robert Rushton Todd (Edinburgh) were elected Fellows of the College.

Congratulations.

On behalf of the College Sir Norman Walker congratulated Dr. George M. Robertson and Sir Robert Philip on receiving the honorary Fellowship of the Royal College of Surgeons of Edinburgh which had recently been conferred upon them.

Other Business.

On the motion by Sir Robert Philip the annual report as Curator of the Laboratory was approved.

It was intimated that Dr. George M. Robertson had been appointed a Trustee of the College.

Medical News.

THE combined meeting of the Section of Neurology of the Royal Society of Medicine and the American Neurological Association, of which we gave full particulars on June 25th (p. 1155), will be opened on the evening of Monday next, July 25th, by a reception at the Royal Society of Medicine, and the guests will be received by Sir James Berry, president of the society, and Lady Berry. At 9.30 p.m. Sir James Purves-Stewart, president of the section, will give an address on "Mount Athos, a survival of the Middle Ages." Tuesday will be given up to the reading of short papers, and on Wednesday morning there will be a discussion on the cerebellum. On Thursday there is to be a discussion on sensory disorders in organic disease of the nervous system, and at 5 p.m. the Hughlings Jackson lecture will be delivered by Dr. Charles L. Dana. During the afternoon demonstrations on pathological subjects will be given, and there will be a dinner in the evening.

CIVIL list pensions of £75 have been awarded to Dr. George Alexander Pirie, in recognition of his self-sacrificing and devoted services to the application of radiology to medicine, and to the widow of Dr. A. C. Inman, in recognition of his contributions to the pathology of tuberculosis. Mr. G. C. W. Williams, F.R.C.S., has received a pension of £50 in recognition of his self-sacrificing and devoted services in the routine application of *x* rays to the treatment of disease.

IN view of the incidence of dermatitis among persons handling flour and sugar, the Home Secretary, after consultation with the National Association of Biscuit Manufacturers, has issued a draft order. The main requirement is the provision and maintenance of suitable washing facilities, but in addition the occupier is required to arrange for a systematic inspection of the hands and forearms of all persons employed in the processes in order to detect early signs of dermatitis. The inspection is to be carried out by a "responsible person" and to be made once a week. If a person whose work brings him into contact with sugar, or a mixture of sugar and other ingredients, shows a tendency to develop, or is known to be susceptible to, dermatitis, he is, if practicable, to be transferred to other work. An official cautionary notice for posting in places where such work is carried on has also been prepared. Objections may be lodged with the Home Secretary within thirty days.

THE Fellowship of Medicine announces that Mr. A. Caddy will give a lecture demonstration on glaucoma at the Royal Westminster Ophthalmic Hospital on July 26th, at 5 p.m., free to medical practitioners. There will be an afternoon course in diseases of infants at the Infants Hospital under the direction of Dr. Eric Pritchard from August 8th to 21st, with special visits to the Model Pasteurizing Plant, Willesden, the Home for Blind Babies, Chorley Wood, and the V.D. Centre, Thavies Inn. A course in medicine, surgery, and the specialties will be held at Queen Mary's Hospital, Stratford, from August 29th to September 10th, during both mornings and afternoons. The Fellowship of Medicine provides a general course of instruction at the associated hospitals for which a comprehensive ticket is issued for any period from one week to one year; the holder is free to make up his own time-table from headings in the programme supplied. Copies of all syllabuses are obtainable from the Secretary of the Fellowship, 1, Wimpole Street, W.1.

THE St. Bartholomew's old students' dinner will be held on Monday, October 3rd, at 7.30 p.m., in the great hall of the hospital, with Dr. H. Morley Fletcher in the chair. The honorary secretaries are Sir C. Gordon-Watson and Mr. R. M. Vick.

DR. P. G. GARRETT, on leaving Earl Shilton, Leicestershire, for Henfield, Sussex, was presented with a hall clock, an illuminated address, and a book containing the names of subscribers.

THE Hanbury Memorial Medal for original research in the chemistry and natural history of drugs has been awarded to T. A. Henry, D.Sc., director of the Wellcome Chemical Research Laboratories.

BY an Order in Council the powers of the University of London Commissioners have been continued to the end of 1928.

THE King has been pleased to appoint Sir James Crawford Maxwell, M.D., K.B.E., C.M.G., to be Governor and Commander-in-Chief of Northern Rhodesia.

FIELD-MARSHAL THE DUKE OF CONNAUGHT has appointed Colonel Sir John Atkins, K.C.M.G., M.B., and Marcus Antonius Johnston De Lavis-Trafford, Esq., O.B.E., M.D., to be Physicians-in-Ordinary to His Royal Highness in the room of Colonel Sir Edward Scott Worthington, K.C.V.O., C.B., C.M.G., C.I.E., M.D., resigned.

THE Exchange Secretary of the National Union of Students (3, Endsleigh Gardens, London, W.C.1) is prepared to recommend young university men or women from France or Germany who would be suitable guests of English families during the summer vacation.

AT the recent examination for the diploma in librarianship of the University of London thirty passed, but none of them will be eligible to receive the diploma until they have furnished the necessary certificate of employment in an approved library.

DR. R. KING BROWN, medical officer of health, Bermondsey, where artificial light therapy has been extensively carried out under the public health department, has been appointed medical editor of the *British Journal of Actinotherapy*.

THE fifty-second annual report of the Mission to Lepers contains a short summary by Dr. R. G. Cochrane of the improvement in the therapeutic outlook in leprosy which has followed the introduction of the ethyl esters of chaulmoogra oil. The number of lepers now being treated directly or indirectly by the Mission exceeds 9,000. Additions were made during 1926 to its institutions in Bihar, Bengal, the Punjab, the Central Provinces, Madras, and China; the civil disturbances in the last-named country have not, it is stated, interfered seriously with the work of the Mission. New buildings of various kinds have also been constructed in Korea and Formosa, and similar extension is contemplated in Kenya and Uganda. The report, which is freely illustrated, contains details of the work in several places. It is published at 6d., and, together with the quarterly magazine of the Mission, *Without the Camp*, for which the subscription is 1s. a year, may be obtained from the secretary of the Mission, 33, Henrietta Street, W.C.2.

Letters, Notes, and Answers.

All communications in regard to editorial business should be addressed to ***The EDITOR, British Medical Journal, British Medical Association House, Tavistock Square, W.C.1.***

ORIGINAL ARTICLES and LETTERS forwarded for publication are understood to be offered to the BRITISH MEDICAL JOURNAL alone unless the contrary be stated. Correspondents who wish notice to be taken of their communications should authenticate them with their names, not necessarily for publication.

Authors desiring REPRINTS of their articles published in the BRITISH MEDICAL JOURNAL must communicate with the Financial Secretary and Business Manager, British Medical Association House, Tavistock Square, W.C.1, on receipt of proofs.

All communications with reference to ADVERTISEMENTS, as well as orders for copies of the JOURNAL, should be addressed to the Financial Secretary and Business Manager.

The ***TELEPHONE NUMBERS*** of the British Medical Association and the BRITISH MEDICAL JOURNAL are *MUSEUM 9861, 9862, 9863,* and *9864* (internal exchange, four lines).

The ***TELEGRAPHIC ADDRESSES*** are:
EDITOR of the BRITISH MEDICAL JOURNAL, *Aitiology Westcent, London.*
FINANCIAL SECRETARY AND BUSINESS MANAGER (Advertisements, etc.), *Articulate Westcent, London.*
MEDICAL SECRETARY, *Mediscera Westcent, London.*

The address of the Irish Office of the British Medical Association is 16, South Frederick Street, Dublin (telegrams: *Bacillus, Dublin*; telephone: 4737 Dublin), and of the Scottish Office, 6, Drumsheugh Gardens, Edinburgh (telegrams: *Associate, Edinburgh*; telephone: 4361 Central).

QUERIES AND ANSWERS.

TREATMENT OF THREADWORMS.

DR. J. FINCH HAINES (West Hampstead) writes in reply to "India": I have found the following treatment for threadworms invariably successful, if regularly persevered in—5 grains of sulphur three times a day, and a teaspoonful of liquid paraffin nightly.

OMENTAL TEARS.

"M.B., CH.B." writes: I have a miner under my care who received an abdominal injury several months ago and still has pain of a character difficult to explain, taking the present findings into consideration. I should be grateful for references to cases of a similar kind and their after-symptoms. The history is briefly as follows: The man was working, along with his colleague in the pit. The latter was swinging a 16 lb. hammer, in the act of hewing coal, when the head flew off. My patient was struck in the abdomen, in the gall bladder region, and became unconscious for a time. His symptoms now are occasional pain on movement exactly over the place of injury, and there is slight rigidity of the rectus muscle in that region. *X*-ray photographs show no abnormality; stomach and duodenum are absolutely normal and the pain is not of muscular origin.

INCOME TAX.

Assistant's Remuneration.

"HUMBER" is in partnership with his brother, and they have employed an assistant as from March 3rd who will probably become a partner as from September 1st. The firm's liability for 1927–28 is based on their earnings for the year to April 5th, 1927, which were reduced by the assistant's salary, etc., for one month, whereas that cost will affect five months of 1927–28.

*** The firm have no remedy. It is a fact that their income tax liability for 1927–28 is likely to exceed their earnings for that year; on the other hand, in 1928–29 their three-sevenths shares of the partnership earnings of that year (including those of the new partner) are likely to exceed their liability, based, as it will be, on the earnings of 1927–28, after deducting the assistant's cost up to the date as from which he becomes a partner. In the long run there should be no appreciable injustice.

Allowable Expenses.

"H. E. B." inquires whether he can deduct as professional expenses (1) salary and cost of board of maid, (2) also of housekeeper, (3) fitting of electric light and power to surgery, (4) subscriptions to British Medical Association and Medical Defence Union, and (5) contributions to fund for accommodating speakers at Annual Meeting of British Medical Association, and subscriptions to Epsom College and medical benefit, etc.

*** (1) and (2) Yes, to the extent or in the proportion to which these employees devote their time to looking after the professional, as distinct from the domestic, side of the establishment—presumably very small as regards the housekeeper. (3) No; this represents capital outlay, though some allowance may be due if the old (? gas) fittings required replacement. (4) Yes. (5) On the whole, we think these deductions would be inadmissible, as representing private or semi-charitable expenditure.

Three Years' Average.

"W. B. K." was employed by the Ministry of Pensions, but that work practically ceased in 1924, and in the year 1924–25 his professional work resulted in a loss. He has now claimed to retain the advantage of the three years' average for 1927–28, and the local inspector refuses to admit that claim.

*** The earnings from the Ministry of Pensions were assessable as those of an employment, and must be severed from consideration of the proper basis of assessment of the general professional earnings, which appear to have commenced in 1924–25. Section 29 of the Finance Act, 1925, which deals with the modification of the change to the previous year's basis of assessment, applies to persons assessable "for the year 1926–27 . . . upon an average of a period of three years or more." If "W. B. K." was not in *general* practice in 1923–24 to an appreciable extent, then his general assessment for 1926–27 would be on the average of 1924–25 and 1925–26—that is, of two years only, and he is not within the Section. He might find out from the inspector whether this is in substance the ground of refusal, and if it is, then apply for a revision of the assessments for each of the three years 1924–25, 1925–26, and 1926–27, to the amount of the actual profits of the year under the provisions of the 1842 Income Tax Act—if that course is worth pursuing, having regard to the amounts of the respective years' earnings and the averages applied.

Motor Car Expenses.

"L. M." bought a car in 1924 for £141; he sold it in 1926 for £50, buying another car for £269. He applied for depreciation allowance last year, but did not receive it, until he explained the above transaction, when he was allowed 15 per cent. on £229=£34.

*** Seeing that the car was not purchased until 1926, depreciation on that car was not claimable in the normal course until 1927–28, and in our opinion the 15 per cent. should have been applied to the full value of £269. As regards the old car, the net cost of replacement, excluding improvement, was apparently £141−£50=£91, and an obsolescence allowance should in fairness be given, though certain technical objections can be raised. That allowance would take the form of including £91 as a professional expense of the year 1926.

LETTERS, NOTES, ETC.

A DISCLAIMER.

DR. EUGEN STEINACH, the University, Vienna, asks us to state that he has no connexion with the Dr. Frederick Heyman Institute. He has been informed that such a connexion is implied in an advertisement which appeared in several London newspapers, and Professor Steinach wishes to protest against the use of his name in this connexion.

THE TESTING OF DISINFECTANTS.

MR. J. F. AINSLIE WALKER, F.I.C., F.C.S. (London, E.C.4), writes with reference to the letter under this heading in our issue of July 9th (p. 79) as follows:

"The original note which supplied material for the test was published by me in the *Practitioner* (vol. lxix, No. 413, 1902). The suggestions put forward in that note were elaborated by Dr. Samuel Rideal and myself in the form of a paper which we read at the Bradford Congress of the Royal Sanitary Institute in 1903. For a number of years the method as described in that paper was adopted officially by Government departments here and in the Colonies, with slight modifications (such as the substitution of a standard sterilized saline solution for distilled water in the preparation of all dilutions of the postulant, where the disinfectant under test was required for use at sea—or sterilized urine where employed in latrine work—but the actual technique remained the same. After the experience of a number of years Dr. Rideal and I decided to embody in the test various improvements which had been suggested by us from time to time, and this we did in the brochure published in our joint names by H. K. Lewis and Co. in 1921."

THE LATE MR. STANFORD MORTON.

IN last week's issue of the JOURNAL (p. 117) occurred a regrettable slip on the part of the printer. In the sentence introducing Lieut.-Colonel A. E. J. Lister's interesting note on the operative skill of the late Mr. Stanford Morton the name appears twice as "Mr. Stanmore Morton." The name was given correctly later on, and it is hoped that his many friends and admirers will excuse the lapse.

VACANCIES.

NOTIFICATIONS of offices vacant in universities, medical colleges, and of vacant resident and other appointments at hospitals, will be found at pages 35, 38 and 39 of our advertisement columns, and advertisements as to partnerships, assistantships, and locumtenencies at pages 36 and 37.

A short summary of vacant posts notified in the advertisement columns appears in the *Supplement* at page 56